Application for Online Access to my Medical Record

Surname:	Date of birth:
First name(s):	
Address: Postcode:	
Email address:	
Telephone number:	Mobile number:

I wish to have access to the following online services (please tick all that apply):

1. Booking appointments	☐
2. Requesting repeat prescriptions	☐
3. Access to parts of my medical record	☐

I wish to access my medical record online and understand and agree with each statement (tick)

1. I have read and understood the information leaflet provided by the practice	☐
2. I will be responsible for the security of the information that I see or download	☐
3. If I choose to share my information with anyone else, this is at my own risk	☐
4. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	☐
5. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible	☐

Signature	Date

For practice use only

Patient NHS number:		Practice computer ID number:	
Identity verified by (staff name)	Date:	Method (tick) Photo ID and proof of residence ☐ Vouching ☐ Vouching with information in record ☐	
Authorised by:			Date:
Date account created:			
Date username and password created:			
Level of record access enabled Contractual minimum √ Other…… ……		Notes / explanation	

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