# Application for online access to my medical record

|  |  |
| --- | --- |
| Surname | Date of birth |
| First name |
| Address   Postcode  |
| Email address |
| Telephone number | Mobile number |

|  |  |
| --- | --- |
| 1. Booking appointments
 | 🞏 |
| 1. Requesting repeat prescriptions
 | 🞏 |
| 1. Accessing 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
 | 🞏 |
| 1. I will be responsible for the security of the information that I see or download
 | 🞏 |
| 1. If I choose to share my information with anyone else, this is at my own risk
 | 🞏 |
| 1. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement
 | 🞏 |
| 1. 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 |

### Please bring photo ID and current (no older than 3 months) utility bill as proof of residence.

|  |
| --- |
| Name of staff member who accepted the form |
| Have you added the code 🞏Have you Printed out form 🞏**OR**Informed patient to collect password from reception next week🞏 | Have you checked the ID OR confirmed that you know the patient 🞏**Method of consent**Vouching 🞏Vouching with information in record 🞏Photo ID and proof of residence 🞏 |
| Authorised by | Date |
| Level of record access enabledProspective 🞏Retrospective 🞏All 🞏Limited parts 🞏Contractual minimum 🞏 | Notes / explanation**Add Read code: 912P** |

### For practice use only