Application for online access to my medical record

Surname:	Date of birth:
First name:	NHS Number:
Address	
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. 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	☐
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. If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible	☐
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	☐
6. If I think that I may come under pressure to give access to someone else unwillingly I will contact the practice as soon as possible.	☐

Signature	Date:

For practice use only

Patient name		Patient NHS number	
Identity verified by (initials)	Date	Method Vouching ☐ Vouching with information in record ☐ Photo ID and proof of residence ☐	
Authorised by		Date	
Date account created			
Date passphrase sent			
Level of record access enabled All ☐ Prospective ☐ Retrospective ☐ Detailed coded record ☐ Limited parts ☐		Notes / explanation	