

## Application for online access to my medical record

Surname	Date of birth
First name	
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	<input type="checkbox"/>
2. Requesting Repeat Prescriptions	<input type="checkbox"/>
3. Summary Medical Record	<input type="checkbox"/>
4. Detailed Coded Record	<input type="checkbox"/>

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

5. I have read and understood the information leaflet provided by the practice	<input type="checkbox"/>
6. I will be responsible for the security of the information that I see or download	<input type="checkbox"/>
7. If I choose to share my information with anyone else, this is at my own risk	<input type="checkbox"/>
8. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	<input type="checkbox"/>
9. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible	<input type="checkbox"/>

Signature	Date
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### For practice use only

Patient NHS number		
Identity verified by (initials)	Date	Method Vouching <input type="checkbox"/> Vouching with information in record <input type="checkbox"/> Photo ID and proof of residence <input type="checkbox"/>
Authorised by (print and sign)		Date
Date account created		
Date passphrase sent		
Level of record access enabled	Notes / explanation	

Prospective <input type="checkbox"/>	
Retrospective <input type="checkbox"/>	
All <input type="checkbox"/>	
Limited parts <input type="checkbox"/>	
Contractual minimum <input type="checkbox"/>	