**Application for online access to medical record**

For patients aged 16 years and over

|  |  |
| --- | --- |
| Surname | Date of birth |
| First name | |
| Address  Postcode  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. *Accessing my medical record* |  |

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

*(Access to medical records can take up to 21 days to authorise)*

|  |  |
| --- | --- |
| 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 internal use only**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Patient NHS number | | Practice computer ID number | | |
| Identity verified by (initials) | Date | Method:  Photo ID and proof of residence   Details:  Vouching   Vouching with information in record  | | |
| Access to Medical Record | | | | |
| Authorised by: | | | Date: | |
| Level of record access enabled  Limited parts (medications, allergies, immunisations)   Contractual minimum (medications, allergies)  | | | | Notes / explanation |

Online Access Application Form

Reviewed April 2019