**Application for online access to my medical record for adults aged 16 years and over**

**Patient to complete and return to their practice, please note it may take up to 4 weeks to process applications:**

|  |  |
| --- | --- |
| Surname | Date of birth |
| First name |
| AddressPostcode |
| 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.  |  |
|  |  |

# For practice use only

Signature

Date

|  |  |
| --- | --- |
| Patient NHS number: | Practice computer ID number |
| Date of named administrator meeting with patient: |  Two types of ID checked Photo ID and proof of residence 🞏Please note the type of ID produced by the applicant here: |
| Authorised by( named administrator):  | Date: |
| Notes reviewed by authorised clinical lead: Dr | Date: |
| Access Approved / Not approved | Date: |
| Date account created:  |
| Date passphrase sent: |
| Level of record access enabled All 🞏Limited parts 🞏 | Notes / explanation |