# Application for online access to my medical record

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| --- | --- |
| Full Name | Date of birth |
| AddressPostcode |
| Home Telephone Number Mobile Telephone Number |
| Email address (PLEASE PRINT CLEARLY) |

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 |  |

**Patient Declaration**

**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 riske.g. if the email address above is shared with another person. |  |
| 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 |  |

|  |  |
| --- | --- |
| Patient Signature | Date |

### For Practice use

|  |  |
| --- | --- |
| Date: | EMIS No: |
| Identity verified by (print full name):Checked by (print full name): | Photo ID seen (state what ID has been seen) |
| Proof of Residence (state what document has been seen) |
|  |  |  |
| Authorised by : |  | Date |