# *Application for online access to my medical record*

|  |  |
| --- | --- |
| Surname | Date of birth |
| First name |
| Address   Postcode  |
| Email address |
| Telephone number | Mobile number |

## A. I wish to have access to the following online services (please tick all that apply):

|  |  |
| --- | --- |
| 1. Booking / cancelling doctor appointments
 | 🞏 |
| 1. Requesting repeat prescriptions
 | 🞏 |
| 1. Updating personal details, e.g. address / phone number
 | 🞏 |
| 1. Limited access to parts of my medical record
 | 🞏 |

**B.** I wish to access my Detailed Coded Record online and understand and agree with each statement (tick)

|  |  |
| --- | --- |
| 1. I have read and understood the information leaflet provided by the practice.
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| 1. I will be responsible for the security of the information that I see or download.
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| 1. If I choose to share my information with anyone else, this is at my own risk.
 | 🞏 |
| 1. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement.
 | 🞏 |
| 1. 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 practice use only

|  |  |
| --- | --- |
| Patient NHS number | Practice computer ID number |
| Identity verified by(initials) | Date | MethodVouching 🞏Vouching with information in record 🞏 Photo ID and proof of residence 🞏 |
| Authorised by  | Date |
| Date account created  |
| Date passphrase sent  |
| Level of record access enabledContractual minimum √Other……………………. ………  | Notes / explanation |