# C:\Users\helen green\Desktop\Southcote Brochure & Logo\southcote-logo.jpg Application for online access to my medical record

**Please ensure you have read the information leaflet: What you need to know about your GP online records BEFORE completing this form.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Surname |  |  | First Name(s) |  |
| Address |  | | | |
| Email address |  | | Date of Birth |  |
| 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. |  |

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

I understand that I may be contacted by the Practice to assess this service and I am happy to provide the above information to Southcote Clinic. **Please submit this completed application form along with photo identification (i.e. photo driving license or passport) to reception.** Please collect your login details in person allowing 21 days to process.

***To be completed by reception staff***

***Copy of identification taken: (please circle) Passport Photo Driving License Other …………………….***

***Staff Name: …………………………………………………………….. Date: ……………………….***

**To be completed by Patient**

**Signature of Patient ………………………………………………. Date of login details collected .......................**

***To be completed by Reception Staff***

***Application form scanned – Date: ……………………………***