**Application for online access to my medical record**

|  |  |
| --- | --- |
| Patient Surname | Patient Date of birth |
| Patient First name | |
| Patient Address  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)

|  |  |
| --- | --- |
| 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 |  |

Patient

Signature

If 11 or over

Date

For proxy access by a parent, family member or carer:

|  |  |  |
| --- | --- | --- |
| Proxy Surname | Proxy Date of Birth | |
| Proxy First Name | | |
| Proxy Address  Postcode | | |
| Proxy Email address | | |
| Relationship of Proxy applicant to patient | | |
| Proxy Signature | | Date |

# For practice use only

|  |  |  |  |
| --- | --- | --- | --- |
| Patient NHS number | | Practice computer ID number | |
| Identity verified by (initials) | Date | Method Vouching   Vouching with information in record   Photo ID and proof of residence  | |
| Authorised by | | | Date |
| Date account created | | | |
| Level of record access enabled: All / Prospective / Detailed / Contractual Minimum | | | |