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

**Surname: Date of Birth:**

**First Name:**

**Address:**

**Postcode:**

**Email Address:**

**Telephone Number: Mobile Number:**

**I wish to have access to the following online services** (please circle all that apply):

Booking appointments yes / no

Requesting repeat prescriptions yes / no

Access to my medical record yes / no

**I wish to access my medical record online and understand and agree with each statement**:

I will be responsible for the security of the information that I see or download yes/no

If I choose to share my information with anyone else, this is at my own risk yes/no

I will contact the practice as soon as possible if I suspect that my account has

been accessed by someone without my agreement yes/no

If I see information in my record that is not about me or is inaccurate, I

will contact the practice as soon as possible yes/no

**Signature Date**

**FOR PRACTICE USE ONLY**

Patient NHS number: Photo I.D type:

 Photo I.D number:

 Photo I.D expiry date:

Identity verified by: Date: Proof of residence type:

(initials) Proof of residence:

 Dated within last 3 months:

Authorised by: Date:

Date account created:

Date Passphrase sent:

Level of record access enabled Notes/Explanation

 Contractual minimum yes/no

 Other