Application for online access to my medical record

Surname:	Date of birth:
First name:	
Address:	
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	

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
Authorized by:		Date:
Date account created:		
Date passphrase sent:		
Level of record access enabled All Prospective Retrospective Detailed Limited parts Contractual minimum		Notes / explanation: