**ROWNER SURGERY**

I am already registered with GP online services and wish to have online access to my records as well.

|  |  |
| --- | --- |
| Surname |  |
| First Name |  |
| Date of Birth |  |
| Address |  |
| Postcode |  |
| Email address |  |
| Home Tel: |   | Mobile Number |  |

Application for online access to my medical record

I wish to access my medical records online and understand and agree with each statement (please tick)

|  |  |
| --- | --- |
| 1. I have read and understood the information leaflet provided by the practice
 |  |
| 1. I will be responsible for the security of the information that I see or download
 |  |
| 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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Identity Verified through (tick all that apply) | Vouching  |  | Name of verifier | Date |
| Vouching from patients record |  |
| Photo ID |  |
| Authorised by |  | Date |  |
| Date account created |  |
| Date sent to Patient |  |