**Application for Online Access to My Medical Record**

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

**Please note:** Family members will need to have individual email addresses

|  |  |
| --- | --- |
| Surname | Date of birth |
| First name |
| Address  |
| Email address |
| Telephone number | Mobile number |

|  |  |
| --- | --- |
| Booking appointments |  |
| Requesting repeat prescriptions |  |
| Access to Allergies, medication and Immunisation information |  |
| Detailed access to my medical record – **Please note you need to have been registered with us for at least 3 months and you will only be able to view documents from the date you registered with this surgery.** |  |

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

|  |  |
| --- | --- |
| I have read and understood the information leaflet provided by the practice |  |
| I will be responsible for the security of the information that I see or download |  |
| If I choose to share my information with anyone else, this is at my own risk |  |
| I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement |  |
| 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 | MethodVouching 🞏Photo ID and proof of residence 🞏 |
| Authorised by  | Date |