

Application for online access to my medical record

In order to register for online services, please bring this form to the practice along with photo ID and proof of your address. The reception team will give you a user name and password. Suitable photo ID includes passport, driving licence, or bus pass. Suitable proof of address includes utility bill or bank statement.

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	<input type="checkbox"/>
2. Requesting repeat medications	<input type="checkbox"/>
3. Accessing my medical record	<input type="checkbox"/>

I wish to have access to 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	<input type="checkbox"/>
2. I will be responsible for the security of the information that I see or download	<input type="checkbox"/>
3. If I choose to share my information with anyone else, this is at my own risk	<input type="checkbox"/>
4. I will contact the Practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	<input type="checkbox"/>
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	<input type="checkbox"/>

Signature	Date
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For practice use only

Patient identity verified by (initials)	Date	Method Photo ID <input type="checkbox"/> Proof of residence <input type="checkbox"/>
Authorised by:	Date	Date on-line account created:
Level of access to record enabled: Booking appointments <input type="checkbox"/> Repeat Medication <input type="checkbox"/> Coded Entries <input type="checkbox"/>		Date password/user name sent: