THIS FORM MUST BE FILLED OUT AND SIGNED BY HAND AND BROUGHT TO THE SURGERY IN PERSON WITH PHOTO ID AND PROOF OF ADDRESS

Application for online access to my medical record (ADMIN)

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 tick all that apply):

• Booking appointments	☐
• Requesting repeat prescriptions	☐
• Access to my clinical record	☐

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

I have read and understood the information leaflet provided by the practice	☐
I understand I will only be able to see my online record from the date of this application	☐
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 (Reception to complete the grey section)

Patient NHS number			
Identity verified by (initials)	Date	Method Vouching ☐ Photo ID and proof of residence ☐	
Authorised by (Admin)			Date (Admin)
Date account created (Admin)			
Date passphrase sent (Admin)			
Level of record access enabled Contractual minimum √ Other…….. ……			Notes / explanation

Updated 23/06/22