APPLICATION FOR ONLINE ACCESS TO MEDICAL RECORDS

By completing this document you are giving explicit consent for the surgery to register your details for you to have access to your information online. Please bring in the form to the surgery once completed.

ALL PATIENTS ARE REQUIRED TO SHOW A PHOTOGRAPHIC FORM OF ID

Once you are registered you will be able to use the service to:

- Order your repeat prescriptions
- See part of your medical records
- Book certain types of appointments
- Review your medications and known allergies

Surname	First Name
Date of Birth	
Address Postcode	
Email address	
Telephone number	Mobile number

I would like access my medical record online and understand and agree with each statement (tick)

1. I will be responsible for the security of the information that I see or download	□
2. If I choose to share my information with anyone else, this is at my own risk	□
3. I understand that it is my responsibility to keep my account secure by keeping my details confidential	□
4. I understand that I can terminate my account at any time by contacting the surgery, or change my log in details by re-registering and that this form will be kept on my electronic records	□

Signature	Date

For Practice use only

Patient NHS number		
Identity verified by (initials)	Date	Method Vouching □ Vouching with information in record □ Photo ID and proof of residence □
Authorised by		Date