Patient Access Application Form

|  |  |
| --- | --- |
| 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):

|  |  |
| --- | --- |
| 1. Booking appointments |  |
| 2. Requesting repeat prescriptions |  |
| 3. Accessing my medical record |  |

I wish to access 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 |  |
| 2. I will be responsible for the security of the information that I see or download |  |
| 3. If I choose to share my information with anyone else, this is at my own risk |  |
| 4. If I suspect that my account has been accessed by someone without my  agreement, I will contact the practice as soon as possible |  |
| 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 |  |
| 6. If I think that I may come under pressure to give access to someone else  unwillingly I will contact the practice as soon as possible. |  |

Date

Signature

**For practice use only**

|  |  |  |  |
| --- | --- | --- | --- |
| Patient NHS number | | Practice computer ID number | |
| Identity verified by (initials) | Date | Method  Vouching Vouching with information in record Photo ID and proof of residence | |
| Authorised by | | | Date |
| Date account created | | | |
| Date passphrase sent | | | |
| Level of record access enabled  All  Prospective  Retrospective  Detailed coded record    Limited parts  | | Notes / explanation | |