

Application for online access to my medical record

Please could you provide 2 proofs of ID 1 Photo and 1 Proof of Address
Driving licence cannot be used for both

Surname	Date of birth
First name	
Address	
Postcode	
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 prescriptions	<input type="checkbox"/>
3. Access to my Detailed Coded Medical Record	<input type="checkbox"/>

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	<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"/>

By completing this form I consent to my username and password to be posted out to me.

Signature	Date
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For practice use only

Patient NHS number		Practice computer ID number
Identity verified by (initials)	Date	Method Vouching <input type="checkbox"/> Vouching with information in record <input type="checkbox"/> Photo ID and proof of residence <input type="checkbox"/> Type of ID seen _____ _____