Seaside
MEDICAL CENTRE

Application for Online Access to My Medical Record

Section 1

Patient Information

Surname	**Date of birth**
First name	
Address	
	Postcode
Telephone number/landline	**Mobile number**
Email address	**Nominated pharmacy**

Section 2

I wish to have access to the following online services (please tick all that apply):

1.	**Requesting repeat prescriptions**	
2.	**Access to my prospective (present/future) medical record**	

Section3

I wish to access my medical record online and by signing below I am confirming that I understand and agree with the following statements.

1.	**I have read and understood the Things to Consider Sheet**	
2.	**I will be responsible for the security of the information I see or download**	
3.	**If I choose to share my information with anyone else, this is at my own risk**	

4.	**I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement**	
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 and complete an enquiry form.**	

Signature	**Date**

For practice use only

Patient NHS number		**Practice computer ID number**
Identity verified by (initials) **Date**		**Method of verification** **Vouching** **Vouching with information in record** **Photo ID and proof of residence**
Online access authorised by		**Date**
Date account created		
Date login credentials emailed/given		
Level of record access enabled **Prescriptions** **Full prospective access** **Full retrospective record from date:** **Detailed coded record from date:**		
Date clinical assurance completed		**Assured by (initials)**
Reason for refusal if record access is refused after clinical assurance		

Once the form has been completed it should be scanned and filed to the patient's record