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