Application form for patient online access

|  |  |
| --- | --- |
| Surname | Date of birth |
| First name |
| Address |
| 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 | □ |
| 3a. Access to my medical records from this date forward | □ |
|  I wish to access my **prospective** medical record online and understand and agree with each statement (tick) |
| 1. I understand that I can request information and educational resources from my GP 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  |  □ |
| Signature Date |  |
| For practice use only |
| Patient NHS number |
| Identity verified by (initials)DateDate | Method used | Vouching □Vouching with information in record □Photo ID and proof of residence □ |
| Documentary evidence provided |  |
| Authorised by | Date |
| Date account created |
| Date login credentials emailed/given |
| Level of record access enabledDetailed coded record □ Full prospective record (automatic) □ Full retrospective record □ Full retrospective record from specific date □  | Notes / explanation |
| Date clinical assurance completed  | Assured by (initials) |
| Reason for refusal if record access is refused after clinical assurance. |