**Application for online access to my medical record**

|  |  |
| --- | --- |
| 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 one option):

|  |  |
| --- | --- |
| Access to my medical record (coded records) This does not include textual entries. | 🞏 |
| Access to my full medical records | 🞏 |
| **Reason for request:** | 🞏 |

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 | | 🞏 |
| I will be responsible for the security of the information that I see or download | | 🞏 |
| If I choose to share my information with anyone else, this is at my own risk | | 🞏 |
| I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement | | 🞏 |
| If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible  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 | | Practice computer ID number | | |
| Identity verified by  (initials) | Date | Method  Vouching 🞏  Vouching with information in record 🞏  Photo ID and proof of residence 🞏  Documentary Evidence provided | | |
| Authorised by | | | | Date |
| Date account created | | | | |
| Date login credentials given | | | | |
| Level of record access enabled  Detailed Coded record | | | Notes / explanation | |