Ainsdale Medical Centre

B

(Form B) Application for online access to medical record

(For new and existing users of Patient Access)

Surname :	**Date of birth : / /**
First name	
Address: **Postcode :**	
Email address :	
Telephone number :	**Mobile number :**
Are you an existing user of Patient Access on-line services? Yes ☐ No ☐	

I wish to access my medical record online and understand and agree with each statement (tick each box)
NB: Medical Record Viewer is currently restricted to medication, allergies and immunisations

1) I have read and understood the information leaflet provided by the 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) 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.	☐
6) If I do see information about another person, whether I know them or not, I will not discuss the details with anyone other than a member of practice staff.	☐

Signature:	**Date: / /**

For practice use only (code to 9RN)

Record of ID provided (1 photo; 1 address)	Checked	Checked by: Date:
ID 1. _____	☐	
ID 2. _____	☐	Counter-signed by: Date:
Notes		

Scan page to patient record: Source = “9RN”, type = “On-line access”. Do Not Workflow to doctor