6. Online Access To Your Health Record

Name	
NHS Number	
Date of Birth	
Address	
Telephone	
Email address	

I wish to have online access to: *Please tick all that apply*

☐ View and book appointment

☐ View and request medication

☐ Access my coded medical record (contains any medical codes that have been recorded

☐ Access my full medical record (contains medical codes and any free text that has been recorded

☐ Access my Summary Care Record

☐ Complete online questionnaires

I wish to access my medical record and understand and agree with each statement: *Please tick all that apply*

☐ I have read and understood the "Important Information" section below

☐ 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 else

☐ If I see information in my record that is not about me, I will log out immediately and contact the practice

Please bring photographic proof of your identification in order for the process to be completed

Signature

Signature	☐ Signed on behalf of the patient
Name	
Date	

Practice Use Only

Identity verified through (tick all that apply)	☐ Self Vouching ☐ Vouching with information in record ☐ Photo ID ☐ Proof of residence ☐ Professional Vouching	
Name of Verifier		Date:
Name of person who authorised and added to SystmOne		Date:
Photocopied this page	☐ Yes - Name:	
Passed for scanning	☐ Yes - Name:	