Park Grove Surgery

On line access application form

Full name	Date of Birth
Address	
Telephone number	Mobile
Email address	

Level of Access required (please tick)

1. Book and cancel appointments (the practice will not grant access to those patients with a history of not attending appointments without cancelling them) ☐
2. Order repeat prescriptions ☐
3. Summary patient record (medications, allergies, sensitivities) ☐
4. Detailed patient record (coded medical information and vaccinations) ☐

I wish to have access to my medical record as indicated above and agree that I will be responsible for the security of the information 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 consent. If I see information in my record that I believe is not about me or inaccurate I will contact the practice as soon as possible.

Signed …… Date ……..

Please note: The practice has the right to remove access to on line services for anyone who does not use them responsibly.

For Practice Use

Documents seen:

Passport ☐ Driving License ☐ Utility bill (dated in last 3 months) ☐ HMRC letter ☐

Other ☐ please specify ……..

Leaflet provided ☐ Staff initials ……