|  |  |  |  |
| --- | --- | --- | --- |
| Surname |  | Forename(s) |  |
| Street  |  | Area |  |
| Town or city |  | Postcode |  |
| Phone number |  | Mobile |  |
| Email |  |
| I wish to have access to the following information (tick which apply): |
| Booking appointments |  |
| Requesting repeat prescriptions |  |
| Accessing my medical record  |  |

I wish to access my health record online and understand and agree with the following statements:

|  |  |
| --- | --- |
| 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. |  |
| If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible. |  |
| 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 |  |

# PLEASE PROVIDE AN IDENTIFICATION DOCUMENT UPON RETURN OF THIS FORM

# For practice use only

|  |  |
| --- | --- |
| Patient NHS number | Practice computer ID number |
| Identity verified by (initials) | Date | MethodVouching Vouching with information in record Photo ID and proof of residence  |
| Authorised by | Date |
| Date account created |
| Date passphrase sent |
| Level of record access enabledAll  Prospective  Retrospective Detailed coded record  Limited parts   | Notes / explanation |