## Lander medical practice

#

 **Application for online access**

|  |  |
| --- | --- |
| Surname | Date of birth |
| First name |
| AddressPostcode |
| Email address |
| Telephone number | Mobile number |

I wish to have access to the following online services (please tick all that apply):

|  |  |
| --- | --- |
| 1. Booking appointments |  |
| 2. Requesting repeat prescriptions |  |
| 3. Accessing my medical record |  |

I wish to access my medical record online and understand and agree with each statement (tick)

|  |  |
| --- | --- |
| 1. I will be responsible for the security of the information that I see or download |  |
| 2. If I choose to share my information with anyone else, this is at my own risk |  |
| 3. If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible |  |
| 4. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible |  |
| 5. 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.  |  |
| Please also provide **TWO** forms of ID – Photo **AND** address verification. |  |

# For practice use only

Signature

Date

|  |  |
| --- | --- |
| 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 |

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