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| WATERHOUSES MEDICAL PRACTICE |

**Access to GP online services**

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

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

|  |  |
| --- | --- |
| 1. Booking appointments online | 🞏 |
| 1. Requesting repeat prescriptions online | 🞏 |
| 1. Accessing limited medical information | 🞏 |

# Application for online access to my medical record

I wish to access my \*medical record online (\**at this time, only repeat medication, allergies and adverse reactions can be viewed*). I understand and agree with each statement as follows: (please tick)

|  |  |
| --- | --- |
| 1. I have read and understood the information leaflet provided by the Practice | 🞏 |
| 1. I will be responsible for the security of information that I see or download | 🞏 |
| 1. If I choose to share my information with anyone else, this is at my own risk | 🞏 |
| 1. I will contact the Practice as soon as possible if I suspect that my account has been accessed by someone without my agreement | 🞏 |
| 1. If I see information in my record that it not about me, or is inaccurate, I will contact the Practice as soon as possible | 🞏 |

|  |  |  |  |
| --- | --- | --- | --- |
| *Signature* |  | *Date* |  |

### For Practice use only

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Identity verified through  (tick all that apply) | Vouching 🞏  Vouching with information in record 🞏  Photo ID 🞏  Proof of residence 🞏 | | Name of verifier | | Date |
| Name of person who authorised (if applicable) |  | | Date | | |
| NHS number |  | Practice computer ID number | |  | |
| Date account created |  | | | | |
| Date passphrase sent |  | | | | |
| Level of record access enabled | Prospective 🞏  Retrospective 🞏  All 🞏  Limited parts 🞏  Contractual minimum 🞏 | | | | |

Form created March 2015 (mdw)