PMG

PRESTIGE MEDICAL GROUP

Dr A E Craig Dr I S Maudsley Dr L A Mervin
Dr M E Astle Dr E R Curtis Dr D Cliff

Surname:	Date of Birth:
First Names:	
Address: Post Code:	
Email Address:	
Telephone:	Mobile:

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

1. Requesting repeat prescriptions	☐
2. 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.	☐

Signature: Date:

For practice use only

Identity verified by (initials)	Date	Method Vouching ☐ Vouching with information in record ☐ Photo ID and proof of residence ☐
Authorised by		Date
Date account created		

Created 19.05.2021

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