



Application for enhanced online access to my medical record

Section 1

Surname		Date of birth
First name		
Address		
Postcode		
Unique email address (Not be shared by another user)		
Telephone number	Mobile number	

Section 2

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

1. Booking appointments	<input type="checkbox"/>
2. Requesting repeat prescriptions	<input type="checkbox"/>
3. Enhanced access to my medical record	<input type="checkbox"/>

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

1. I have read and understood the information leaflet provided by the practice	<input type="checkbox"/>
2. I will be responsible for the security of the information that I see or download	<input type="checkbox"/>
3. If I choose to share my information with anyone else, this is at my own risk	<input type="checkbox"/>
4. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	<input type="checkbox"/>
5. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible	<input type="checkbox"/>

Section 3

I agree for my mobile number & email address to be used by the Surgery as a form of communication.	<input type="checkbox"/>
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Signature.....	Date.....
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Please print, sign & return the form to the Surgery in person, with your **identification** in order to collect your registration letter for Patient Access.

For practice use only

Patient NHS number:		Practice computer ID number:	
Identity verified by (initials)	Date	Method Vouching <input type="checkbox"/> Vouching with information in record <input type="checkbox"/> Photo ID and proof of residence <input type="checkbox"/>	
Authorised by:		Date:	
Date account created:			