Alresford Surgery

Application for 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	☐
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 have read and understood the information leaflet provided by the practice	☐
2. I will be responsible for the security of the information that I see or download	☐
3. If I choose to share my information with anyone else, this is at my own risk	☐
4. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	☐
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	☐

Section 3

I agree for my mobile number & email address to be used by the Surgery as a form of communication.	☐

Signature.....	Date.....

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 ☐ Vouching with information in record ☐ Photo ID and proof of residence ☐
Authorised by:		Date:
Date account created:		