|  |  |  |  |
| --- | --- | --- | --- |
| Surname |  | Forename(s) |  |
| Street |  | Area |  |
| Town or city |  | Postcode |  |
| Phone number |  | Mobile |  |
| Email |  | | |
| I wish to have access to the following information (tick which apply): | | | |
| Booking appointments | | |  |
| Requesting repeat prescriptions | | |  |
| Accessing my medical record | | |  |

I wish to access my health record online and understand and agree with the following statements:

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

# PLEASE PROVIDE AN IDENTIFICATION DOCUMENT UPON RETURN OF THIS FORM

# 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 | | | | |
| Date passphrase sent | | | | |
| Level of record access enabled  All   Prospective  Retrospective   Detailed coded record   Limited parts  | | Notes / explanation | | |