**The Stubbington Medical Practice**

**Application for online access to my medical record**

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

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. If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible |  |
| 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 |  |
| 6. 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:

I give consent to my information being sent by e-mail Yes  No 

**PLEASE RETURN THE FORM TO A RECEPTIONIST WHO WILL REQUIRE TO SEE A FORM OF PHOTOGRAPGIC IDENTIFICATION OR PROOF OF RESIDENCE**

# For practice use only

|  |  |  |
| --- | --- | --- |
| Patient NHS number | Practice Emis ID number |  Registered GP initials |
| Identity verified by (initials) | Date | Method: Vouching (personal knowledge of individual) Photo ID / proof of residence Passport number:Driving license number:Other: |
| Authorised by: | Date |
| Date account created: |
| Date passphrase sent: |
| Level of record access enabledAll Prospective Retrospective Detailed coded record Limited parts   | Notes / explanation |