



## Application for online access to my medical record

Please complete the Patient Access registration request below. You will need to **be registered with the Practice and provide proof of identity (you will need to do this in person)**.

Surname	Date of birth
First name	
Address	
Postcode	
Email address	
Telephone number	Mobile number

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

Booking appointments	<input type="checkbox"/>
Requesting repeat prescriptions	<input type="checkbox"/>
Access to parts of my medical record as currently available	<input type="checkbox"/>

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

I have read and understood the information leaflet provided by the practice	<input type="checkbox"/>
I will be responsible for the security of the information that I see or download	<input type="checkbox"/>
If I choose to share my information with anyone else, this is at my own risk	<input type="checkbox"/>
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"/>
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"/>

Signature	Date
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### For practice use only

NHS number		Emis ID number	
Identity verified by (initials)	Date	Photo ID and proof of residence <input type="checkbox"/> Vouching with non-photo ID <input type="checkbox"/> Vouching with information in record <input type="checkbox"/>	
Authorised by		Date	
Date account created			
Date passphrase sent			
Level of record access enabled Appts, prescriptions & summary <input type="checkbox"/> Detailed coded record <input type="checkbox"/>		Notes / explanation	

