**

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

|  |  |
| --- | --- |
| Surname  | Date of birth  |
| First name  |
| Address |
| Pt contact details:Email: Tel: Mobile:  |
| NHS 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. 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 | [ ]  |
| 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