# Application form For Online access to my Medical Records

|  |  |  |  |
| --- | --- | --- | --- |
| Surname |  | | Date of Birth |
| First Name(s) |  | | |
| Address | Post Code | | |
| Telephone Number |  | Mobile Number | |
| Email |  | | |

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

|  |  |
| --- | --- |
| 1. Booking appointments | 🞏 |
| 1. Requesting repeat prescriptions | 🞏 |
| 1. 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 | 🞏 |
| 1. I will be responsible for the security of the information that I see or download | 🞏 |
| 1. If I choose to share my information with anyone else, this is at my own risk | 🞏 |
| 1. if I suspect that my account has been accessed by someone without my agreement I will contact the practice as soon as possible | 🞏 |
| 1. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible | 🞏 |
| 1. 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. | 🞎 |

I understand that I may be contacted by the practice to assess this service and I am happy to provide the above information to Dr. Malik Surgery.

Please submit this completed application form along with photocopy of identification (i.e. photo driving license or passport to reception

Allow 5 working days, (if you are not requesting access to detailed coded records) or 21 days(if detailed coded access is required)to process your application before collecting your logging in person ( a signature will be required)

|  |  |
| --- | --- |
| Signature | Date |

For Practice use only

|  |  |  |  |
| --- | --- | --- | --- |
| Patient NHS Number | | Practice Computer ID | |
| Identity Verfied by  (intials) | Date | Method  Vouching 🞎  Vouching with information in record 🞎  Photo ID and proof of residence 🞎 | |
| Authorised by | | | Date |
| Date Account Created | | | |
| Date Login details given Patient signature | | | |
| Level of Record Access enabled  Detailed Coded Recorded 🞎 Limited Parts 🞎  No Care Record Access 🞎 Core summary care Record 🞎 | | | |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

V5 27 January2016