# Dr Malik Practice

|  |  |  |  |
| --- | --- | --- | --- |
| Surname |   |  First Name(s) |  |
| Address |   |
| Date of Birth |  |  Telephone  |  |
| Mobile Tele |  | Consent to be contacted by text message and **to** **opt-in the appointment reminder text service** ? **Yes / No** (please select option) |
| Email |  |

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

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 detailed coded medical record |  |

**Please tick the following statements to indicate that you have read, understood and agreed with each statement**

|  |  |
| --- | --- |
| 1. I have read and understood the information leaflets 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 or that I may come under pressure to give access to someone else unwillingly |  |
| 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. **YES – I am happy to provide my email address to Dr Malik Practice for the purpose of receiving information, newsletters health promotion invites and patient surveys etc.** *Note: You can opt-out anytime* |  |
|  |  |



Please submit this completed application form along with photo identification (i.e. photo driving licence or passport) to reception. A copy of the ID may be taken but NOT scanned into clinical record.

Please collect your login details in person allowing 7 days to process.

***To be completed by Reception Staff***

Copy of photo identification taken:  *Passport  Photo Driving Licence  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Contact Details Updated on Computer *: Telephone + Mobile*  * Email Address *

Register Patient for Patient Access on SystmOne + Instructions & Login details printed **

**Level of record access enabled:**

No Care Record Access  Core Summary Care Record  Detailed Coded Record 

Partial Clinical Record  Full Clinical Record 

Staff Name & Signature: ……………………….……….…………..………… Date……………….…………………….

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***To be completed by Patient***

Signature of Patient ……………………………………….………Date of login details collected: ……………..……………

***To be completed by Reception Staff*** Application form only scanned ** Form filed **