# Application for online access to my medical record

|  |  |
| --- | --- |
| 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):

|  |  |
| --- | --- |
| 1. Booking appointments | 🞏 |
| 1. Requesting repeat prescriptions | 🞏 |
| 1. Viewing Summary Care Records | 🞏 |
| 1. Detailed Coded Record Information Including Test Results, Vaccinations, Blood Pressure, Diagnosis, Call Recalls, Care Plans, Drug Sensitivities | 🞏 |

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, download or Print | 🞏 |
| 1. If I choose to share my information with anyone else, this is at my own risk | 🞏 |
| 1. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement | 🞏 |
| 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. I understand, If I am applying for Parental/guardian access of a child once he/she attains the age of 11 years, online access will be switched off and further access will be reviewed on a case by case basis by the GP Partners in this practice. | 🞏 |

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

If request is for access to be given to someone other than the patient please complete this section:

|  |  |
| --- | --- |
| Access to be provided to |  |
| Relationship to patient |  |
| Please tick as appropriate | Proxy Access for Child 🞏 Proxy Access for Carer 🞏  See Box A See Box B |
| **A** | Access will discontinue on the 11th birthday  Access is applied for prescription requesting and appointment booking only  Patient identification must be seen for the patient (Birth Certificate) and person requiring proxy access. |
| **B** | In the event of Mental incapacity evidence of Lasting Power of Attorney for Health and Welfare must be seen  Patient identification must be seen for the patient and person requiring proxy access.  Access is applied for prescription requesting and appointment booking only |

**For Practice Use Only**

|  |  |
| --- | --- |
| Patient NHS Number |  |
| Identity Verified by |  |
| Method | **Passport** 🞏  **Driving License** 🞏  **Birth Certificate** 🞏  **Utility Bill** 🞏  **Other (Description):** |
| If Appropriate  Evidence of Lasting Power of Attorney for Health and Welfare Viewed.  Evidence of Parental Responsibility provided |  |
| Detailed Coded Access – Medical Records Reviewed and Authorized by: |  |
| Date Account Created and Password Posted to Patient: |  |