Patient Access Application Form

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	☐
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. If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible	☐
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

For practice use only

Patient NHS number	Practice computer ID number	
Identity verified by (initials)	Date	Method
		Vouching ☐
		Vouching with information in record ☐
		Photo ID and proof of residence ☐
Authorised by		Date
Date account created		
Date passphrase sent		
Level of record access enabled		Notes / explanation
All ☐		
Prospective ☐		
Retrospective ☐		
Detailed coded record ☐		
Limited parts ☐		