

- Please BRING TWO FORMS OF ID WITH YOU – Photo ID AND proof of address.

- ALSO YOU MUST BRING YOUR OWN PAPER WORK BACK!!!!

Horsmans Place Surgery

Application for Online Access to my medical record

|  |  |  |
| --- | --- | --- |
| Surname: | DOB: | |
| First Name: | | |
| Address & Postcode: | | |
| Email Address: | | |
| Mobile Number: | | Telephone Number: |

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 records |  |

I wish to access my medical records online and understand and agree with each statement (tick)

|  |  |
| --- | --- |
| 1. I have read and understood the information leaflet provide 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, it 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 |  |
| Signature: | Date: |

**For PRACTICE use only!**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Patient NHS number | | | Practice computer ID number | |
| Identity Verified by | Date | | | Method: |
|  |  | | | Vouching  Vouching with information in record  Photo ID and proof of resident |
| Authorised by: | | | | Date: |
| Date account created: | | Date passphrase sent: | | |
| **Level of record access enabled:**  Prospective Retrospective All Limited Parts Contractual minimum | | | | |