Horsmans Place Surgery

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

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

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 recordPhoto 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   |