Application for Access to my Patient Online Services

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 summary medical record	
4. Accessing my detailed coded record	

I wish to access my medical record online and understand and agree with each statement ***(please tick):***

1. I will be responsible for the security of the information that I see or download	
2. If I choose to share my information with anyone else, this is at my own risk	
3. If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible	
4. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible	
5. 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:		Patient Date of Birth:	
Identity verified by (initials):	Date:	Method (please tick):	Vouching ☐ Vouching with information in record ☐ Photo ID and proof of residence ☐
Authorised by:		Date:	
Date log in details given to patient:			
Notes / comments:			