**Application form for online access to the practice online services**

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| **Patient details** | | | | | | |
| **Full name** | |  | | | | |
| **Date of Birth** | |  | | | | |
| **Address** | |  | | | | |
| **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. Accessing my medical record | | | | |  | |
| **I wish to access my medical record online and understand and agree with each statement:** | | | | | | |
| 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 or download | | | | | |  |
| 1. If I choose to share my information with anyone else, this is at my own risk | | | | | |  |
| 1. If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible | | | | | |  |
| 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. 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** |  | | |

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| **For practice use only** | | | |
| Identity verified & attached by:  Date: | Vouching | |  |
| Vouching with information in record | |  |
| Photo ID and proof of residence | |  |
| Authorised by: | Date: | | |
| Level of record access enabled: | Detailed coded record |  | |
| All prospective |  | |
| All retrospective |  | |
| Other limited parts |  | |
| Redactions made: | Comments | | |
| Date clinical assurance completed | Assured by (initials) | | |
| Reason for refusal if record access is refused after clinical assurance | | | |