**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 |