



## Application for online access to my medical record

Surname | Date of birth:  
First name:  
Email address:  
Telephone number:  
Mobile number:

Providing you mobile number indicates your agreement for the practice to contact you via call or text.

### 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 core summary medical record ☐

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

1. I have read and understood the information leaflet provided by the practice ☐
2. I will be responsible for the security of the information that I see or download ☐
3. If I choose to share my information with anyone else, this is at my own risk ☐
4. If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible ☐
5. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible ☐
6. 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:	EMIS ID number:
Identity verified by:	Date:
Method: Vouching <input type="checkbox"/> Vouching with information in record <input type="checkbox"/>	Photo ID and proof of residence <input type="checkbox"/>
Authorised by:	Date:
Date account created:	Date passphrase sent
Level of record access enabled: Prospective <input type="checkbox"/> Retrospective <input type="checkbox"/> Detailed coded record <input type="checkbox"/> Limited parts <input type="checkbox"/>	
Demographic details confirmed <input type="checkbox"/>	Demographic details updated: <input type="checkbox"/>