# Application For Online Access To My GP Medical Record

|  |  |  |
| --- | --- | --- |
| Surname: | | Date of birth: |
| First name(s): | | NHS No: |
| Address:      Postcode: | | |
| Email address: | | |
| Home 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. Access to parts of my 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 | 🞏 |
| 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. 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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **NHS number**: | | **EMIS ID**: | | | | **1. Date Request**  **Rec’d** (stamp): | |
| **2. Identity verified by:**  (staff name) | **3. Date:** | | | **4. Method of ID Verification (tick one)**  Vouching 🞏  Photo ID and proof of residence 🞏  Vouching with information in record 🞏 | | | |
| **5. Sent To:** | | | | | | | **6. Date:** |
| **7. GP To Complete**:  Access Granted 🞏 OR Access Denied 🞏 | | | | | GP Signature: | | |
|  | | | | | | | |
| **8. Date account**  **created:** | | | **9. Level of record access enabled**  Contractual minimum 🗹  Other……………………. ……… | | | | |
| **10. Notes / explanation:** | | |  | | | | |