# Application For Online Access To My GP Medical Record

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| --- | --- |
| 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:** |  |