The Grange Medical Centre

# Application for online access to my medical record

For Patients over the age of 16 only

|  |  |
| --- | --- |
| Surname | Date of birth  |
| First name |
| Address:  |
| Email address  |
| Tel:  | Mobile:  |

## I wish to have access to the following online services (please tick all that apply):

|  |  |
| --- | --- |
| 1. Booking appointments
 | ❑ |
| 1. Requesting repeat prescriptions
 | ❑ |
| 1. Limited access to parts of my medical record detailed access
 | ❑ |

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

|  |  |
| --- | --- |
| Patient NHS number | Practice computer ID number |
| Identity verified by:(initials) | Date:  | Method Vouching ❑Vouching with information in record ❑ Photo ID and proof of residence ❑ |
| Authorised by:  | Date |
| Level of record access enabledContractual minimum 🗹Other: ……………………………….… | Notes / explanation |