Patient Access Application Form

PLEASE ENSURE YOU HAND THE COMPLETED FORM BACK TO RECEPTION WITH PHOTO ID

Surname	Date of birth
Frist name	
Address Postcode	
Email Address	
Telephone number	Mobile number

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 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		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
Date account created		
Date passphrase sent		
Level of record access enabled All ☐ Prospective ☐ Retrospective ☐ Detailed coded record ☐ Limited parts ☐		Notes / explanation