King Edward St Medical Practice

Application for online access to my medical record

Surname:	Date of birth:
First 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. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	☐
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	☐

Signature	Date

For practice use only

Patient NHS No:		Practice computer ID:
Identity verified by:	Date:	Method Vouching ☐ Vouching with information in record ☐ Photo ID and proof of residence ☐
Date account created:		Date passphrase sent:
Level of record access enabled ☐ Retrospective ☐ All ☐ Limited parts ☐ Prospective ☐ Contractual minimum		ACCEPTABLE FORMS OF ID (two must be ticked) ☐ Driving Licence ☐ Passport ☐ Bod Card ☐ Bank Statement
DCR Enabled: Yes ☐ No ☐		Date:
Authorising Clinician		Signature: