Application Form for Patient Online Access

**Section 1**

**Patient Information**

|  |  |
| --- | --- |
| Surname | Date of Birth (DD/MM/YYYY) |
| First name | NHS number |
| Address  Postcode | |
| Telephone number | Mobile number |
| Email address | |

**Section 2**

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

1. Booking appointments
2. Requesting repeat prescriptions
3. Access to my (future) medical record

**Please note:** by default, you will be able to view record content when signing up to GP online services. Exclusions apply. If you **do not wish** to have this access, please tick here

**Section 3**

**I wish to access my medical record online and by signing below I am confirming that I understand and agree with the following statements**

1. I understand that I can request information and educational resources from my GP 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 of patient …………………………………………………… Date ……………………

**For Practice Use Only**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Patient NHS number | | | | | |
| Identity verified by  Date | Method of verification  Vouching  Vouching with information in record  Photo ID and proof of residence | | | |  |
| Documentary evidence provided | | | | | |
| Online access authorised by | | | | Date | |
| Date account created | | | | | |
| Date login credentials emailed/given | | | | | |
| Level of record access enabled  Appointment booking and prescriptions  Full prospective record  Full retrospective record from date: \_\_\_\_\_\_\_\_\_\_\_  Detailed coded record from date: \_\_\_\_\_\_\_\_\_\_\_\_ | |  | Notes/explanation | | |
| Date clinical assurance completed | | Assured by (initials) | | | |
| Reason for refusal if record access is refused after clinical assurance | | | | | |

**Once the form has been completed it should be scanned and filed to the patient’s record**