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 byDate | 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 enabledAppointment 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**