highgrove surgery

Application for online access to my medical record

PLEASE COMPLETE ALL FIELDS (AS REQUIRED)

Surname	Dateofbirth
Firstname	
Address **Emailaddress (must be supplied and clearly legible!):**	
Telephonenumber	Mobilenumber

Iwish to haveaccesstothefollowingonlineservices(please tickallthatapply):

1.Bookingappointments	☐
2.Requestingrepeatprescriptions	☐
3.Accessing mymedical record	☐

Iwish toaccessmymedical recordonlineandunderstandandagreewith eachstatement (tick)

1.Ihave readandunderstood theinformationleafletprovided bythe practice	☐
2.Iwill be responsiblefor thesecurity ofthe informationthatIsee ordownload	☐
3.IfI choosetosharemyinformationwithanyoneelse,thisisatmy ownrisk	☐
4.Iwillcontact the practice assoonaspossibleifIsuspect that myaccounthasbeenaccessedbysomeone without myagreement	☐
5.IfIsee information inmyrecordthat isnotabout meorisinaccurate, Iwillcontact thepracticeas soon aspossible	☐

Signature	Date

Forpracticeuseonly

PatientNHSnumber		
Identity verifiedby(initials)	Date	Method Vouching☐ Vouchingwithinformationinrecord☐ Photo ID☐
Authorised by		Date
Dateaccountcreated		
Datepassphrasesent		
Level ofrecordaccessenabled Summary☐Pros pective☐Retros pective☐		Notes /explanation