Online Access Application Form

Application for online access to my medical records

Surname	
First Name	
Date of Birth	
Email Address	
Telephone Number	
Address	

I wish to have access to the following services (Please tick all that apply)	
1. Booking appointments	
2. Request repeat prescriptions	
3. Accessing my medical records	

I understand and agree with each statement below (Please tick all that apply)	
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 this information with anyone else, it is at my own risk**	
4. **I will contact the practice as soon as possible if I suspect that someone has accessed my online account within 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**	

Name (BLOCK CAPITALS)	**Signature**	**Date**

STAFF ONLY

Initials of staff member	**Signature**	**Date**	**Please confirm what ID you have seen (e.g. passport/utility bill – needs to be one of each. Bank cards are not a form of ID)**