CHIDDINGFOLD SURGERY

APPLICATION FOR ONLINE ACCESS TO MY MEDICAL RECORD

Surname:	**Date of birth:**
First Name:	
Address:	
Post code:	
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:

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 records 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 Number:		**Practice computer ID Number:**	
Identity verified by (initials):	**Date:**	**Method:** **Vouching** **Vouching with information** **Photo ID and proof of residence**	
Authorised by:		**Date:**	

Level of record access enabled		**Notes / Explanation**
All		
Prospective		
Retrospective		
Detailed		
Limited parts		
Contractual minimum		