|  |
| --- |
| Surname: Date of Birth: |
| First Names: |
| Address:  Post Code: |
| Email Address: |
| Telephone: Mobile: |

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

|  |  |
| --- | --- |
| 1. Requesting repeat prescriptions |  |
| 2. Accessing my medical record |  |

I wish to access my medical record online and understand and agree with each statement (tick)

|  |  |
| --- | --- |
| 1. I will be responsible for the security of the information that I see or download |  |
| 2. If I choose to share my information with anyone else, this is at my own risk |  |
| 3. If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible |  |
| 4. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible |  |
| 5. 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: Date:

# For practice use only

|  |  |  |  |
| --- | --- | --- | --- |
| Identity verified by (initials) | Date | Method  Vouching   Vouching with information in record   Photo ID and proof of residence  | |
| Authorised by | | | Date |
| Date account created | | | |

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