**Sele Medical Practice**

**Application for online access to my medical record**

|  |  |
| --- | --- |
| Surname | Date of Birth |
| First name | |
| Address  Postcode | |
| Email address | |
| Telephone number | Mobile number |

I wish to have access to the following online services and this includes allergy and immunisation information (please tick all that apply):

|  |  |
| --- | --- |
| 1. Booking appointments |  |
| 2. Requesting repeat prescriptions |  |

You can also apply for access to view your main medical records online which would include

consultations, test results and documents. It may take us longer to authorise this, up to 21 days.

Please tick the box below if you would like this type of access and provide two forms of ID, at

least one of which must be Photo ID. Unfortunately, legally we are unable to accept utility bills.

|  |  |
| --- | --- |
| 3. Full medical record access |  |

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

|  |  |
| --- | --- |
| 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 record 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 in record   Photo ID and proof of residence  | |
| Authorised by | | | Date |
| Date account created | | | |
| Date passphrase sent | | | |