SOUTH HERMITAGE SURGERY

Section A: Application for online access to my medical record

First name:	Surname:	Date of birth:
Address: Postcode:		
Email address:		
Telephone number:		Mobile number:
Do you already have a Patient Access account?	Yes ☐	No ☐
Which is your preferred contact method?	Post ☐	Email ☐

Section B: ***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 (please complete Section C and provide ID)	☐

Section C: Only required if patient has ticked option 3 in Section B

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. If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible	☐
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	☐
6. 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:

Section D:

Identification required (only needed if Section C complete):
*** Photo ID eg passport or driving licence **AND***
*** Proof of address eg bank statement or utility bill*

For practice use only

Patient NHS number		Practice computer ID number
Identity verified by (initials)	**Date**	**Method:** ☐ Photo ID – details…….. ☐ Proof of residence – details…….. ☐ Vouching ☐ Vouching with information in record
Date account created		
Level of record access enabled: All ☐ Limited parts ☐		Notes / explanation
Name of Person who authorised		Date

****OFFICE STAFF – PLEASE ENSURE PATIENT RETAINS THEIR GUIDELINES SHEET**