PARKLANDS SURGERY

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 (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 (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	☐
6.**Online access password already issue** **(Please tick one box only)**	☐
7. **New password required** **(Please tick one box only)**	☐

Signature	Date

For practice use only

Proxy user details: Name: Date of Birth:		Proxy user details: Email: Relationship:
Identity verified by	Date	Method Vouching ☐ Vouching with information in record ☐ Photo ID and proof of residence ☐
		Date
Date account created		
Date passphrase sent		
Level of record access enabled Prospective ☐ Retrospective ☐ All ☐ Limited parts ☐ Contractual minimum ☐		Notes / explanation