# Application for Online Access to my Medical Record

Reception

Staff Initials

|  |  |
| --- | --- |
| First Name | Date of birth |
| Surname  |
| 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 Medical appointments
 |  |
| 1. Requesting repeat prescriptions
 |  |
| 1. Accessing my Summary Care Record (***SCR***)
 |  |
| 1. Accessing my Detailed Coded Record (***DCR***)
 |  |

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
 |  |
| 1. I will be responsible for the security of the information that I see or download
 |  |
| 1. If I choose to share my information with anyone else, this is at my own risk
 |  |
| 1. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement
 |  |
| 1. 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 |
| Preferred contact method (*please tick at least one*):   SMS Email Letter    |
| I consent to receiving SMS message from the practice   YES NO  |

### For Practice Manager / Management Support Officer use ONLY

|  |  |
| --- | --- |
| Patient NHS number | Identity verified by (staff initials) |
| Date | MethodVouching 🞏Vouching with information in record 🞏 Photo ID and proof of residence 🞏 |
| Authorised by  | Date |
| Date account created  |
| Date passphrase given to patient |
| Level of record access enabled Prospective 🞏Retrospective 🞏 All 🞏Limited parts 🞏Contractual minimum 🞏 | Notes / explanation |