# 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***) (standard access) | 🞏 |
| 1. Accessing my Detailed Coded Record (***DCR***) (enhanced 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 | 🞏 |
| 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*): Email SMS   Letter | |
| I consent to receiving SMS message from the practice Yes No | |

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Patient NHS number | | Practice computer ID number | | |
| Identity verified by | Date | Method  Vouching 🞏  Vouching with information in record 🞏  Photo ID and proof of residence 🞏 | | |
| Authorised by | | | | Date |
| Date account created | | | | |
| Date passphrase sent | | | | |
| Level of record access enabled Prospective 🞏  Retrospective 🞏  All 🞏  Limited parts 🞏  Contractual minimum 🞏 | | | Notes / explanation | |