THE SHAFTESBURY AVENUE SURGERY

Application for online access to my medical record

Please note 2 forms of ID are required, of which one should be photo ID such as Passport or Driving license, the other must be a bank or mortgage statement or a utility bill.

Surname……First name……

Address……

……..

Date of birth……..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 YES [ ] NO [ ]
2. Requesting repeat prescriptions YES [ ] NO [ ]
3. Limited access to parts of my medical record YES [ ] NO [ ]

I wish to access mov medical record online and understand and agree with each statement (tick)
1. I have read and understood the information leaflet provided by the practice YES [ ] NO [ ]
2. I will be responsible for the security of the information that I see or download YES [ ] NO [ ]
3. If I choose to share my information with anyone else, this is at my own risk YES [ ] NO [ ]
4. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement YES [ ] NO [ ]
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 YES [ ] NO [ ]

We will contact you with; your password when this has been set up for you.
Please remember to keep all the account details secure. If you think the account details may have been shared with someone you should reset them straight away. If you have any queries or concerns about the service or wish to withdraw from the service, please speak to our practice manager

Signature……..Date……

For practice use only | Patient NHS number

Practice computer ID number……Identity verified by (initials)……..

Date……

Method:

Vouching YES[ ] NO [ ] Vouching with information in record YES[ ] NO[ ] Photo ID and proof of residence YES[ ] NO[ ]

Authorised by…… Date……..

Date account created……..Date Password……