|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Surname |  | | | | | Date of birth |  | |
| First names |  | | | | | | | |
| Address |  | | | | | | | |
| Post code |  | Email |  | | | | | \*🞏 |
| Telephone |  | | | Mobile |  | | | \*🞏 |

\* Please tick after email / Mobile if you consent to the practice contacting you about appointments and health campaigns.

**I wish to have access to the following online services** *(Please tick all that apply)*

|  |  |  |  |
| --- | --- | --- | --- |
| Appointment booking | 🞏 | Request repeat prescriptions | 🞏 |
| Basic access to my medical record | 🞏 | Demographics, Allergies/Adverse Reactions, Medication (dose, quantity and last issued date) |  |
| Detailed access to my medical record  *(Requires authorisation by your GP)* | 🞏 | (Basic access + Immunisations, Results (numerical values and normal range), Values (BP, PERF), Problems/Diagnoses, Procedure Codes (medical or surgical) and codes in consultation (signs, symptoms), Codes showing referral made or letters received (no attachments), Other Codes (ethnicity, QOF) |  |
| Full Clinical Record *(Requires authorisation by your GP)* | 🞏 | Text consultations & Record attachments (available from the date the records have been reviewed until) plus detailed 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 Medical Centre. | | 🞏 |
| 1. I will be responsible for 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 Medical Centre 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 Medical Centre as soon as possible. | | 🞏 |
| 1. If I think that I may or have come under pressure to give access to someone else unwillingly, I will contact the Medical Centre as soon as possible. | | 🞏 |
| **Signature** | **Date** | |

**For practice use only**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Patient NHS No. | |  | | | | Practice computer ID No. | | | |  | |
| **Identity** Photo ID and proof of residence seen (Passport, Driving licence etc) | | | | | | | | | Verified by | | Date |
| Access authorised by (Reception): | | | | | | | | | Date | | |
| Detailed Access by GP | | | | | | | Reason not approved | | | | |
| Approved 🞏 | | | Not approved 🞏 | | | |
| Signed |  | | | | | | | Date |  | | |
| Level of record access enabled | | | | | Notes | | | | | | |
| Appointments | | | | 🞏 |
| Repeat requests | | | | 🞏 |
| Basic record access | | | | 🞏 |
| Detailed record access  Full Clinical access | | | | 🞏  🞏 | Enabled Date / By | | | | | | |