|  |  |  |  |
| --- | --- | --- | --- |
| 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)*

|  |  |  |  |
| --- | --- | --- | --- |
| Appointments | 🞏 | Request repeat prescriptions | 🞏 |
| Detailed coded access to my medical record*(Requires records review by your GP)* | 🞏 | (Demographics, Allergies/Adverse Reactions, Medication, Immunisations, Results, Tests, 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 from 1.11.2023 or registration date | 🞏 | Date / /  | Text consultations & Record attachments (available from the date the records have been reviewed until) plus detailed access. |
| Full Clinical Record *(Requires records review 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.  |  |
| **Identity** Photo ID and proof of residence seen (Passport, Driving licence etc) | Verified by | Date |
| Access authorised by (Reception):  | Date |
| Records Access by GP | Reason not denied |
| Approved 🞏 | Not approved 🞏 |
| Signed |  | Date |  |
| Level of record access enabled | Notes |
| Appointments | 🞏 |
| Repeat requests | 🞏 |
| Detailed coded records access | 🞏 |
| Record access from / / | 🞏 | Enabled Date / By |
| Full Clinical access | 🞏 |