# SOUTH HERMITAGE SURGERY

**Application for online access to my medical record**

*Section A:*

|  |
| --- |
| First name:  Surname: Date of birth: |
| Address:   Postcode: |
| Email address: |
| Telephone number: |  Mobile number: |
|  Do you already have a Patient Access account? |  Yes No    |
|  Which is your preferred contact method?  |  Post Email    |

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

*Section B:*

|  |  |
| --- | --- |
| 1. Booking appointments |  |
| 2. Requesting repeat prescriptions |  |
| 3. Accessing my medical record (please complete Section C and provide ID) |  |

***I wish to access my medical record online and understand and agree with each statement (tick)***

*Section C: Only required if patient has ticked option 3 in Section B*

|  |  |
| --- | --- |
| 1. I have read and understood the information leaflet provided by the practice |  |
| 2. I will be responsible for the security of the information that I see or download |  |
| 3. If I choose to share my information with anyone else, this is at my own risk |  |
| 4. If I suspect that my account has been accessed by someone without my  agreement, I will contact the practice as soon as possible |  |
| 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 |  |
| 6. If I think that I may come under pressure to give access to someone else  unwillingly I will contact the practice as soon as possible.  |  |
| Signature:Date:  |

***Identification required (only needed if Section C complete):***

*\*\* Photo ID eg passport or driving licence* ***AND***

*\*\* Proof of address eg bank statement or utility bill*

*Section D:*

# *For practice use only*

|  |  |
| --- | --- |
| Patient NHS number | Practice computer ID number |
| Identity verified by (initials) | **Date** |  **Method:** Photo ID – details……………….. Proof of residence – details……………….. Vouching Vouching with information in record |
| Date account created |
| Level of record access enabled:All  Limited parts   | Notes / explanation |
| Name of Person who authorised |  Date |

 **\*\*OFFICE STAFF – PLEASE ENSURE PATIENT RETAINS THEIR GUIDELINES SHEET**

22/9/17