# 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