Application Form for Patient Online Access

**Section 1**

**Patient Information**

|  |  |
| --- | --- |
| Surname | Date of Birth (DD/MM/YYYY) |
| First name | NHS number |
| Address  Postcode | |
| Telephone number | Mobile number |
| Email address | |

**Section 2**

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

1. Requesting repeat prescriptions

2. Access to my (future) medical record

**Please note:** by default, you will be able to view record content from November 2022 onwards, or from your date of registration at any new GP Practice you move to. Exclusions apply.

If you wish to have access to your past medical record, tick the box below

3b. Access to my (past) medical record, to view past content from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (enter date)

**Please note:** There may be a significant delay in processing your application if you wish to request this level of access. This is to allow time for a necessary review of your record. Exclusions apply.

**Section 3**

**I wish to access my medical record online and by signing below I am confirming that I understand and agree with the following statements**

1. I understand that I can request information and educational resources from my GP 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 of patient …………………………………………………… Date ……………………

**For Practice Use Only**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Patient NHS number | | | | | |
| Identity verified by  Date | Method of verification  Vouching  Vouching with information in record  Photo ID and proof of residence | | | |  |
| Documentary evidence provided | | | | | |
| Online access authorised by | | | | Date | |
| Date account created | | | | | |
| Date login credentials emailed/given | | | | | |
| Level of record access enabled  Prescriptions  Full prospective record  Full retrospective record from date: \_\_\_\_\_\_\_\_\_\_\_  Detailed coded record from date: \_\_\_\_\_\_\_\_\_\_\_\_ | |  | Notes/explanation | | |
| Date clinical assurance completed | | Assured by (initials) | | | |
| Reason for refusal if record access is refused after clinical assurance | | | | | |

**Once the form has been completed it should be scanned and filed to the patient’s record**