# Forest House Medical Centre & Warren Lane Surgery

**Application for online access to my medical record – Clinical Record**

|  |  |
| --- | --- |
| Surname | Date of birth |
| First name | |
| Address  Postcode | |
| Email address | |
| Telephone number | Mobile number |

I wish to have access to the following online services

|  |  |
| --- | --- |
| I wish to have access to my detailed coded record |  |
| I wish to have access to my full clinical record (please be aware access will be given from the date requested not historically)  given from the |  |
| I understand this may take 2-3 weeks to activate |  |

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 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

If access is for a child Parents Signature …………………………………………

# For practice use only

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Patient NHS number | | | Enter read code XaPnA | |
| Identity verified by (initials) | Date | | Method  Vouching   Photo ID and proof of residence  | |
| Signature of staff member | | | | Date |
| Date account created | | | | |
|  | | Staff enter ID seen below | | |

**P drive\practice information\protocols & policies\reception**