#

# Forest House Medical Centre & Warren Lane Surgery

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

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

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

|  |  |
| --- | --- |
| 1. Booking appointments |  |
| 2. Requesting repeat prescriptions |  |
| 3. SCR (Summary Care Records) – Medication prescribed & allergies |  |

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

|  |  |
| --- | --- |
| 1. I will be responsible for the security of the information that I see or download |  |
| 2. If I choose to share my information with anyone else, this is at my own risk |  |
| 3. If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible |  |
| 4. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible |  |
| 5. 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.  |  |
|  |  |

Patients signature ………………………………………………..

Date

# For practice use only

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