**PENN SURGERY - Application for Patient Online Access form**

|  |  |  |  |
| --- | --- | --- | --- |
| Surname |  | Forename(s) |  |
| Full Address |  | Date of birth |  |
| Tel. number |  | Mobile |  |
| Email |  |
| Next of kin Name & tel No. |  |
| I wish to have access to the following information (tick those which apply): |
| Booking appointments |  |
| Requesting repeat prescriptions |  |
| Accessing my medical record |  |

I wish to access my health record online and understand and agree with the following statements:

|  |  |
| --- | --- |
| I have read and understood the information leaflet provided by the practice. |  |
| I will be responsible for the security of the information that I see or download. |  |
| If I choose to share my information with anyone else, this is at my own risk. |  |
| If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible. |  |
| If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible. |  |
| 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 |  |

***Practice staff are to complete the sections overleaf***

**For practice use only**

|  |  |
| --- | --- |
| Patient NHS number | Practice computer ID number |
| Identity verified by (initials) | Date | MethodVouching Vouching with information in record Photo ID and proof of residence  |
| Authorised by | Date |
| Date account created |
| Date passphrase given |
| Level of record access enabledAll  Prospective  Retrospective Detailed coded record  Limited parts   | Notes/explanation |