**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 | | Method  Vouching   Vouching with information in record   Photo ID and proof of residence  | |
| Authorised by | | | | Date |
| Date account created | | | | |
| Date passphrase given | | | | |
| Level of record access enabled  All   Prospective  Retrospective   Detailed coded record   Limited parts  | | Notes/explanation | | |