

Water Meadow Surgery

Application for online access to my medical record

Surname	Date of birth
First Name	
Address	
Email address	
Telephone number	Mobile number

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

1. Booking appointments	<input type="checkbox"/>
2. Requesting repeat medications	<input type="checkbox"/>
3. Accessing my medical record	<input type="checkbox"/>

I wish to have access to 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	<input type="checkbox"/>
2. I will be responsible for the security of the information that I see or download	<input type="checkbox"/>
3. If I choose to share my information with anyone else, this is at my own risk	<input type="checkbox"/>
4. I will contact the Practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	<input type="checkbox"/>
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	<input type="checkbox"/>

Signature	Date
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For practice use only

Patient identity verified by (initials)	Date	Photo ID <input type="checkbox"/> Proof of residence <input type="checkbox"/> Personal Vouching <input type="checkbox"/>
Authorised by:	Date	Date on-line account created:
Level of access to record enabled: <ul style="list-style-type: none">• Booking appointments <input type="checkbox"/>• Repeat Medication <input type="checkbox"/>• Summary Care Record <input type="checkbox"/>• Detailed Coded Record Entries <input type="checkbox"/>		Date password/user name sent: