

Application for online access to my medical 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 (please tick all that apply):

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

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. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement
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

<p>I understand and agree with the statements given above by ticking this box. If this box is not ticked I acknowledge that it will not be possible to grant me online access of any kind.</p>	<input style="width: 100%; height: 100%;" type="checkbox"/>
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SIGNED:	DATE:
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