**ST LUKE'S SURGERY**

# Application for online access to my medical record

## (For 12-15 Age Group)

| | |
|---|---|
| Surname | Date of birth |
| First name | |
| Address<br><br>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 | |
| 2. Requesting repeat prescriptions | |
| 3. Accessing my medical record | |

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|---|
| 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 |

| | |
|---|---|
| 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. | |

| | |
|---|---|
| SIGNED: | DATE: |

**Please note: This request will be passed to your registered GP for consideration, the GP will let you know if this has been approved.**