

Summerhill Surgery

APPLICATION FOR ONLINE SERVICES/ACCESS TO MY MEDICAL RECORD

Surname	Date of birth
First name	
Address	
Email address *A unique email is required for every individual using our on line services	
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 showing immunisations and allergies only	<input type="checkbox"/>

I wish to access my * detailed coded 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"/>

***Please note access to detailed coded data requires GP approval**

Signature	Date
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For practice use only

Patient NHS number	Practice computer ID number	
Identity verified by (initials)	Date	Method Vouching <input type="checkbox"/> Vouching with information in record <input type="checkbox"/> Photo ID and proof of residence <input type="checkbox"/>
Authorised by		Date
Date account created		
Date passphrase sent		
Level of record access enabled All <input type="checkbox"/> Prospective <input type="checkbox"/> Retrospective <input type="checkbox"/> Detailed <input type="checkbox"/> Limited parts <input type="checkbox"/> Contractual minimum <input type="checkbox"/>	Notes / explanation Email Sent (initials)	