**Section 1: Patient Details:**

|  |  |  |  |
| --- | --- | --- | --- |
| Full name |  | Date of Birth |  |
| Address |  | Home Tel |  |
| Mobile No |  |
| Postcode |  | Email address |  |

**Section 2: Online Service Options**

I would like to apply for the following online services:

|  |  |
| --- | --- |
| Requesting repeat prescriptions |  |
| Booking appointments |  |
| Access to Detailed Coded Medical Record |  |

**Section 3: Terms and Conditions:**

I, the patient, understand and agree with each of the following statements:

|  |  |
| --- | --- |
| 1. I have read and understood the information leaflet provided by the Practice |  |
| 1. I will be required to provide photographic identification before I can access online services (e.g. driving license, passport, identity card, etc.) |  |
| 1. I will be provided with an account activation code that will be unique to me and it is my responsibility to keep my username and passwords secure. If I believe these have been shared inappropriately or suspect that my account has been accessed without my agreement I will reset them using instructions via the Patient Access website. If I choose to share my information with anyone else, I understand this is at my own risk |  |
| 1. If I see information in my record that is not about me, or is inaccurate, I will log out immediately and contact the practice as soon as possible |  |
| 1. It is my responsibility to notify the Practice of any change in my contact details |  |
| 1. If I think that I may come under pressure to give access to someone else unwillingly at any time, I will inform a member of the practice team as soon as possible. |  |
| 1. I understand that online access is granted at the discretion of the practice, taking into account my best interests. I will be informed of any decision to withdraw the service. *Please note, this does not affect your rights of Subject Access under the Data Protection Act.* I understand that the practice reserves the right to withdraw my access to online services if I misuse this service. |  |
| **For requests for Access to Detailed Coded Medical Records:** | |
| 1. I understand the Practice makes every effort to record information as accurately as possible, however there may be information that I may not feel is correct. If I notice any inaccuracies with my record, I will inform the Practice Manager as soon as possible of any errors or omissions |  |
| 1. I understand that I may see information on my record that I was unaware of / have forgotten about that could cause distress |  |
| 1. I understand that, as before, I will be informed directly by the practice of any test results which require further action. However, I understand that I may see these results online before the practice has been able to contact me. This could be whilst the surgery is closed and there is no one available to discuss them with me |  |
| 1. I understand that the information may not be a complete record and I should not rely on it for insurance purposes |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Signature: *(to be signed at Reception by patient)* |  | Date: |  |

**Your request for access may take up to 25 working days to process.**

**You will be informed if access cannot be granted**

**For practice use only:**

|  |  |  |  |
| --- | --- | --- | --- |
| Identity verified through:  (tick all that apply) | Photo ID  Proof of residence  Vouching  Vouching with information in record | Name of verifier: | Date: |

|  |  |  |
| --- | --- | --- |
| **For requests for Access to Detailed Coded Medical Records:** | | |
| Records Checked By (GP): |  | Date Checked: |
| Outcome of record check: | Access to be granted: Yes  No  If no, state reason:  Date patient/patient representative(s) informed if access denied: | |
| Level of Access to Records to be granted | All  Detailed Coded  Free Text  Documents | |

|  |  |  |  |
| --- | --- | --- | --- |
| Account created by (Initials): | Date created: | Account details sent to patient by (initials): | Date sent: |