**Patient online record viewing application form for adults aged 16 and over.**

**This form needs to be completed if you would like to access to your medical records online, this would be via your preferred online service provider I.E. NHS APP.**

**PLEASE ENSURE YOU HAVE YOU HAVE A FORM OF FORMAL PHOTO ID WHEN HANDING IN THIS FORM AS WE CANNOT GRANT ACCESS WITHOUT VERIFYING YOUR IDENTIFICATION.**

|  |  |
| --- | --- |
| Name  |   |
| Date of birth  |   |
| Address    |   |
| Postcode  |   |
| Email address  |   |
| Telephone number  |   | Mobile number  |   |

**Application for online access to my medical record**

*I wish to access my medical record online and understand and agree with each statement (please tick)*

|  |  |
| --- | --- |
| 1. I have read and understood the information leafletprovided by the practice which can be found on our website under the Online Service tab. |   |
| 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 it not about me, or is inaccurate I will logout immediately and contact the practice immediately via Secure Messaging within my Patient Access account or I will contact the practice by telephone after 2pm  |   |
| 6. Are you happy to have your Linkage key, ODS Code and Account ID emailed to your personal email address? |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Signature  |    | Date  |   |

**Office use only**:

Identification documents seen. Name: Signature:

 PIN document Patient check Details checked/updated Settings checked/updated Patient Coded