**The Dicconson Group Practice**

Application for online access to my medical record

|  |  |
| --- | --- |
| Surname | Date of birth |
| First name  |
| Address  Post code |
| Email address |
| Telephone Number  | Mobile number |

I wish to have access to the following online services (please tick all that apply)

|  |  |
| --- | --- |
| 1. Booking appointments
 |  |
| 1. Requesting repeat prescriptions
 |  |
| 1. Accessing my medical record – medications/allergies/demographics & immunisations.

 < 16Yrs will have access to appointment booking and repeat prescriptions. |  |

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

|  |  |
| --- | --- |
| 1. I have read and understood the information leaflet provided by the practice
 |  |
| 1. I will be responsible for the security of the information that I see or download
 |  |
| 1. If I choose to share my information with anyone else, this is at my own risk
 |  |
| 1. I will contact the practice as soon as possible if I suspect that my account had been accessed by someone without my agreement
 |  |
| 1. If I see information in my record that is not about me or is inaccurate, I will be contact the practice as soon as possible
 |  |

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

**For practice use only**

|  |  |
| --- | --- |
| **Patient NHS number**  | **Practice computer ID number**  |
| **Identified by (name)****Verified on registration tab – EMAIL & NUMBER****Verified on patient details EMAIL & NUMBER** | **Date** | **Vouching I.D sited** * **Driving licence**
* **Passport**
* **Utility bill**
* **Bank statement**
* **Other (please detail)**
 |
| **Authorised by**  | **Date**  |