PENN SURGERY - Application for Patient Online Access form

Surname		Forename(s)	
Full Address		Date of birth	
Tel. number		Mobile	
Email			
Next of kin Name & tel No.		Relationship to you	
I wish to have access to the following information (tick those which apply):			
Booking appointments			
Requesting repeat prescriptions			
Accessing my medical record			

I wish to access my health record online and understand and agree with the following statements:

I have read and understood the information leaflet provided by the practice.	
I will be responsible for the security of the information that I see or download.	
If I choose to share my information with anyone else, this is at my own risk.	
If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible.	
If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible.	
If I think that I may come under pressure to give access to someone else unwillingly I will contact the practice as soon as possible.	
Signature	
Date	

Once complete please hand to the surgery reception team. ID must be confirmed

For practice use only

<table>
<tr><td colspan="2">Patient NHS number</td><td colspan="2">Practice computer ID number</td></tr>
<tr><td>Identity verified by (initials)</td><td>Date</td><td colspan="2">Method
Vouching ☐
Vouching with information in record ☐
Photo ID and proof of residence ☐</td></tr>
<tr><td colspan="3">Authorised by</td><td>Date</td></tr>
<tr><td colspan="4">Date account created</td></tr>
<tr><td colspan="4">Date passphrase given</td></tr>
<tr><td colspan="2">Level of record access enabled
All ☐
Prospective ☐
Retrospective ☐
Detailed coded record ☐
Limited parts ☐</td><td colspan="2">Notes/explanation</td></tr>
</table>