ALWOODLEY MEDICAL CENTRE

Application for online access to my medical record

Surname	Date of birth
First name	
Address Postcode	
Email address	
Telephone number	Mobile number

Online services includes:-

- Booking appointments
- Requesting repeat prescriptions - **We would like to send your prescription electronically to your pharmacy**

  Please nominate a Pharmacy……

- Access to your medical records

I wish to have access to online services **please tick** ☐

I understand and agree with each statement (tick)

• 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	☐
• I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	☐
• If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible	☐

Signature	Date

For practice use only

Patient NHS number		Practice computer ID number
Identity verified by (initials)	Date	Method Vouching ☐ Vouching with information in record ☐ Photo ID and proof of residence ☐
Authorised by		Date
Date account created		
Date passphrase sent		
Level of record access enabled All ☐ Contractual minimum ☐		Notes / explanation