Fullwell Cross Medical Centre

Application for online access to my medical record

Surname

First name

Date of birth

Address

Postcode

Email address

Telephone number

Mobile number

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

1. Booking appointments ☐
2. Requesting repeat prescriptions ☐
3. Accessing my medical record ☐

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

1. I have read and understood the information leaflet provided by the practice ☐
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 is not about me or is inaccurate, I will contact the practice as soon as possible ☐

Signature	Date

Fullwell Cross Medical Centre

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 sent</td></tr>
<tr><td colspan="2">Level of record access enabled
Prospective ☐
Retrospective ☐
All ☐
Limited parts ☐
Contractual minimum ☐</td><td colspan="2">Notes / explanation</td></tr>
</table>