***Practice name Selsdon Park Medical Practice***

**Application Form for Online Access to my Medical Record**

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

|  |  |  |
| --- | --- | --- |
| I wish to have access to the following online services. Please tick Yes or No | Yes  | No  |
| 1. Booking appointments
 |  |  |
| 1. Requesting repeat prescriptions
 |  |  |
| 1. Accessing my medical record
 |  |  |

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

|  |  |
| --- | --- |
| 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 has 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 contact the practice as soon as possible |  |
|  |  |
|  Patient Signature  |  Date  |  |