Ivel Medical Centre

Application for online access to my medical record

Surname	Date of birth
First name	
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 and cancelling appointments	☐
2. Requesting repeat prescriptions	☐
3. Limited access to parts of 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	☐
2. If I choose to share my information with anyone else, this is at my own risk	☐
3. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	☐
4. 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 Prospective ☐ Retrospective ☐ All ☐ Limited parts ☐ Contractual minimum ☐		Notes / explanation	