KINGSTHORPE MEDICAL CENTRE

APPLICATION FOR PATIENT ONLINE ACCESS

Surname		**Forename(s)**	
Address		**Postcode**	
Home Telephone		**Mobile**	
Email Address			
I wish to have access to the following information (tick which apply)			
Booking appointments			
Requesting Repeat Prescriptions			
Access 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	

Practice staff to complete sections overleaf

(ONLINE ACCESS)

FOR PRACTICE USE ONLY

<table>
<tr><td>Patient NHS Number</td><td colspan="2"></td></tr>
<tr><td>Identity verified by:</td><td>Date:</td><td>Method
Vouching □
Vouching with information in record □
Photo ID and proof of residence □</td></tr>
<tr><td>Authorised By:</td><td></td><td>Date:</td></tr>
<tr><td>Date account created:</td><td colspan="2"></td></tr>
<tr><td>Date passphrase sent:</td><td colspan="2"></td></tr>
<tr><td colspan="2">Level of record access enabled:

All □
Prospective □
Retrospective □
Detailed coded record □
Limited parts □</td><td>Notes / Explanation</td></tr>
</table>