CITY VIEW MEDICAL PRACTICE

Application for online access to my medical record

Surname	Date of birth
Forename(s)	NHS Number (if known)
Address Postcode	
Email address	
Telephone number	Mobile number

Online Services includes:

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

  Please nominate a Pharmacy of your choice.....

- 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 Contractual minimum ☐ All ☐		Notes/explanation