

## Application for online access to my medical record (OVER 16's ONLY).

A higher standard of documentation is needed for online registration. You will need two forms of documentation, one of which must contain a photo. Acceptable documents include passports, photo driving licences and bank statements (see attached list). Online login details will be emailed/texted to you (providing you have consented) only after you have responded to an automated verification message.

<b>Surname:</b>		<b>Date of birth:</b>	
<b>First name:</b>			
<b>Address:</b>			
Email address:			
Telephone number:		Mobile number:	

**Please note: By providing an email address and mobile number you are agreeing to be contacted by Preston Park Surgery using these contact details.**

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

1. Booking appointments	<input type="checkbox"/>
2. Requesting repeat prescriptions	<input type="checkbox"/>
3. Accessing my Summary Care Record (SCR)	<input type="checkbox"/>
4. Accessing my Detailed Coded Record <b>Please note:</b> There is a waiting list for this functionality due to the high workload required in checking and enabling coded record access. Access cannot be granted until your medical record has been received from your previously surgery and summarised, which currently takes approximately 8 weeks. Full records access it not available at this surgery.	<input type="checkbox"/>

### 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.	<input type="checkbox"/>
2. I will be responsible for the security of the information that I see or download	<input type="checkbox"/>
3. If I choose to share my information with anyone else, this is at my own risk.	<input type="checkbox"/>
4. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement.	<input type="checkbox"/>
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.	<input type="checkbox"/>
Signature	Date

### For practice use only

<b>RECEPTION DEPARTMENT</b>			
<b>ID verified by (initials):</b>	<b>Date:</b>	ID Provided <input type="checkbox"/> (give details) _____	Vouching <input type="checkbox"/> (give details) _____
<b>ADMIN DEPARTMENT</b>			
Patient NHS number:		Verification message sent:	
<b>Level of record access enabled:</b> Booking appointments <input type="checkbox"/> Requesting repeat prescriptions <input type="checkbox"/> SCR <input type="checkbox"/>		<b>Level of record access enabled:</b> Detailed Coded Record <input type="checkbox"/>	
<b>Authorised by:</b>	<b>Date:</b>	<b>Authorised by:</b>	<b>Date:</b>