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Woolton House
MEDICAL CENTRE

Application for online access to my medical record

Title: Surname: First names:

Date of birth:

Address:

Home telephone		Do you give consent for us to call you on this number? Yes/no
Work telephone		Do you give consent for us to call you on this number? Yes/no
Mobile		Do you give consent for us to text or call you on this number? Yes/No
Email		Do you give consent for us to email you? Yes/no

I wish to have access to the following online services:

Booking appointments Yes/no

Requesting repeat prescriptions Yes/no

Accessing my medical record Yes/no

I will be responsible for the security of the information that I see or download Yes/no

If I choose to share my information with anyone else this is at my own risk Yes/no

I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement Yes/no

If I see information in my record that I think is inaccurate I will inform the practice as soon as possible Yes/no

The practice reserves the right to remove online access.

Signed: Date:

For practice use
Date account created: Identity verified by: Authorised by: Type of ID seen: Email sent: yes/no