# 

# Forest House Medical Centre & Warren Lane Surgery

**14 YEARS & ABOVE**

**Application for online access to my medical record**

|  |  |
| --- | --- |
| Surname | Date of birth |
| First name | |
| Address  Postcode | |
| Email address | |
| Telephone number | Mobile number |

Please tick what you would like to have access to

|  |  |
| --- | --- |
| I wish to have access to book appointments |  |
| I wish to have access to request repeat prescriptions |  |
| I wish to have access to the SCR (summary care record) |  |
| I wish to have access to my full clinical record (please be aware access will be given from the date requested not historically) |  |

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. If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible |  |
| 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 |  |
| 5. 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. |  |
|  |  |

Patients signature ………………………………………………..

Date

# For practice use only

|  |  |  |
| --- | --- | --- |
| ID seen: | Date account created: | |
| Identity verified by (initials): | Method: Vouching   Photo ID and proof of residence  | |
| Signature of staff member: | | Date: |