St Mary's Surgery

Application for online access to my medical record – to be completed if patient wishes to have access to their full medical record

By completing this form you are asking us to make your information we hold in Practice available to you securely over the internet. Your information will not be made available without your permission. If you decide to withdraw it, it will not affect your treatment in any way. **Please note – individual email and mobile numbers are required for each person**

Surname			
First name			
Date of birth			
Address			
Postcode			
Email Address			
Home phone number		Mobile phone number	

Please read the following before completing the statements:

1. Forgotten history – there may be something you have forgotten about which could cause distress
2. Abnormal results/bad news – you may see this before you have spoken to the doctor, or while the surgery is closed and you cannot contact them
3. Coercion – if you think you will be pressured into revealing details from within your record to someone else, against your will, please reconsider using this service
4. Errors in your record – in this case please contact the surgery to enable us to correct your record

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 it not about me, or is inaccurate I will log out immediately and contact the practice as soon as possible	☐
If I feel if I am being coerced into revealing details from my record I shall contact the surgery to remove this access	☐

Patient Confirmation

I wish to access my medical record online and understand and agree with each statement (please tick).

I confirm that the details outlined above are a true and accurate representation.

Signature		Date	

For practice use only

Identity verified (one photo ID and one address ID)	Photo ID ☐ …….. Proof of residence ☐ …….. Vouching ☐ By ……	Name of verifier	Date
Date Online account created & initials			
Date password sent by email or collection for Online Access & initials			
EMIS No			