ILKLEY MOOR MEDICAL PRACTICE

Application for online access to my medical record

Surname	Date of birth
First name	
Address Postcode	
Email address	
Telephone number	Mobile number
Preferred method of contact	Email / SMS / Letter

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

1. Booking appointments	☐
2. Requesting repeat prescriptions	☐
3. Accessing my medical record	☐

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	☐
2. I will be responsible for the security of the information that I see or download	☐
3. If I choose to share my information with anyone else, this is at my own risk	☐
4. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	☐
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	☐

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 All ☐ Prospective ☐ Retrospective ☐ Detailed ☐ Limited parts ☐ Contractual minimum ☐		Notes / explanation	