**Felixstowe Road Medical Practice**

**Application for online access to medical records**

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| **Full Name:** | **NHS Number (If Known)** |
| **Mr / Mrs / Miss / Ms / Other……..** | **Date of Birth:** |
| **Address and Postcode:** | **Telephone Number:** |
| **Mobile Number:** |
| **E-mail Address:** |
|  |
| **I wish to have access to the following online services :**  |
| **Booking appointments** | **Y / N** |
| **Requesting repeat prescriptions** | **Y / N** |
| **Accessing my medical record** | **Y / N** |
| **I wish to have access to my medical online record and agree to the following statements:** |
| * I have read and understood the attached information on keeping you information safe
* I assume responsibility for the security of the information that I can see or download
* If I choose to share my information with anyone else this is undertaken at my own risk
* I will contact the surgery as soon as possible if I suspect that my account has been accessed by somebody else without my agreement
* If I see that the information in my record is not about me or is inaccurate. I will log off the online service and contact the surgery as soon as possible
 |
| **Signature:** | **Date:** |
| **Office use only:** | **Photo Id+1 verified by:****Date:** | **Authorised by: Date:****Notes:** |



**To register for online services you will need the appropriate identity evidence**

**The options for presentation of documents are as follows:**

* Two pieces of level 3 evidence; or
* One piece of Level 3 evidence and one piece of Level 2 evidence

In either case, one piece of evidence must include a photograph. Please attend the surgery with the appropriate original documentation and your completed application form.

**Table- Acceptable identity evidence**

