Scott Park Surgery

Application for online access to my medical record

Surname		First Name(s)	
Address			
Date of Birth		Telephone	
Mobile Tele		Consent to be contacted by text message for care promotion services and appointment reminder text service etc**?** **Yes / No**	
Email			

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

1.	Booking appointments	☐
2.	Requesting repeat prescriptions	☐
3.	Accessing detailed coded medical record	☐
4.	Accessing PROSPECTIVE full medical record from date of registration / request	☐

Please tick the following statements to indicate that you have read, understood and agreed with each statement

1.	I have read and understood the information leaflets 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 or that I may come under pressure to give access to someone else unwillingly	☐
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	☐
6.	**YES – I am happy to provide my email address to Scott Park Surgery and its Patient Reference Group for the purpose of receiving information, newsletters health promotion invites and patient surveys etc.** *Note: You can opt-out anytime*	☐

Signature	Date

Please submit this completed application form along with photo identification (i.e. photo driving licence or passport) to reception. A copy of the ID may be taken but NOT scanned into clinical record.

Please collect your login details in person allowing 7 days to process.

To be completed by Patient

Signature of Patient …………………….……………….…………Date of login details collected: …………….…………….

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