

**Application for access to coded medical records via Patient Online Services**

Surname	Date of birth
First name	
Address:	
Email address	
Tel:	Mobile:

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

1. Access to coded data in my GP medical record via Patient Online Services	<input type="checkbox"/>
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***I wish to access my medical record online and understand and agree with each statement (tick)***

2. I have read and understood the information leaflet provided by the practice	<input type="checkbox"/>
3. I will be responsible for the security of the information that I see or download	<input type="checkbox"/>
4. If I choose to share my information with anyone else, this is at my own risk	<input type="checkbox"/>
5. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	<input type="checkbox"/>
6. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible	<input type="checkbox"/>
Signature:	Date:

**For practice use only**

Patient NHS number:		Patient Identification provided (list items provided): 1)  2)	
Identity verified by: (initials)	Date:		
Authorised by (Practice or Senior Manager):			Date:
Additional Notes:			

