

St Johns House Medical Centre

Application for Online Access to Medical Services

Surname	Date of birth	
First name		
Address		
Postcode		
Email address		
Telephone	Mobile number	

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

1. Booking appointments	<input type="checkbox"/>
2. Requesting repeat prescriptions	<input type="checkbox"/>
3. Accessing my medical record	<input type="checkbox"/>
LINKAGE KEY LETTER ISSUED	<input type="checkbox"/>

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

1. I will be responsible for the security of the information that I see or download	<input type="checkbox"/>
2. If I choose to share my information with anyone else, this is at my own risk	<input type="checkbox"/>
3. If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible	<input type="checkbox"/>
4. 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"/>
5. If I think that I may come under pressure to give access to someone else unwillingly I will contact the practice as soon as possible.	<input type="checkbox"/>

Signature	Date
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For practice use only – Once verified by Reception, give form to Summarisers

Patient NHS number		Practice computer ID number	
Identity verified by (initials)	Date	Method	Vouching <input type="checkbox"/> Vouching with information in record <input type="checkbox"/> Photo ID and proof of residence <input type="checkbox"/>
Summariser Review by		Date	
GP Authorised by:		Date	
Level of record access enabled All <input type="checkbox"/> Prospective <input type="checkbox"/> Retrospective <input type="checkbox"/> Detailed coded record <input type="checkbox"/> Limited parts <input type="checkbox"/>	Notes / explanation		
EMIS Activated by:		Date	
Letter sent to Patient:		Date	
SCAN TO PATIENT RECORD			

