

# Application for online access to my medical record

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

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

Booking appointments	<input type="checkbox"/>
Requesting repeat prescriptions	<input type="checkbox"/>
Accessing my medical record and test results	<input type="checkbox"/>

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

I have read and understood the information leaflet provided by the practice	<input type="checkbox"/>
I will be responsible for the security of the information that I see or download	<input type="checkbox"/>
If I choose to share my information with anyone else, this is at my own risk.	<input type="checkbox"/>
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"/>
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"/>
I will comply with any security checks deemed necessary to verify my identity	<input type="checkbox"/>

Save and email this form to [garswood.surgery1@nhs.net](mailto:garswood.surgery1@nhs.net) (we will contact you to verify your identity)

**OR**

Download, sign and post this form to Garswood Surgery, Billinge Road, Garswood, Wigan, WN4 0XD

**OR**

Download, sign and photograph or scan this form and return by email to [garswood.surgery1@nhs.net](mailto:garswood.surgery1@nhs.net)

Signed:	Date:
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**Remember to enclose or attach your signed ID and proof of address**

## For practice use only

Patient NHS number		EMIS ID number	
Application received by: Post <input type="checkbox"/> Online <input type="checkbox"/> In Person <input type="checkbox"/>			
Post	Application verified against Signed Photo ID and proof of residence <input type="checkbox"/> No ID - Vouching with information in record <input type="checkbox"/> Incomplete application – Patient contacted		
Online and digital signature	Signed Photo ID and proof of residence received <input type="checkbox"/> Digital signature compared against signed photo ID <input type="checkbox"/>		
Online – unsigned application	Returned to patient for signature <input type="checkbox"/> Phone call verification to number held on record <input type="checkbox"/>		
In Person	No ID - Vouching by recognition <input type="checkbox"/> No ID - Vouching with information in record <input type="checkbox"/> Signed Photo ID and proof of residence <input type="checkbox"/> Signature compared against signed photo ID <input type="checkbox"/>		
ID Verified by	Authorised by	Account created (date)	log in details sent
Level of record access enabled Prospective <input type="checkbox"/> Retrospective <input type="checkbox"/> All <input type="checkbox"/> Limited parts <input type="checkbox"/> Contractual minimum <input type="checkbox"/>		Notes / Explanation	