IVY GROVE SURGERY

APPLICATION FOR ACCESS TO ONLINE SERVICES
MEDICAL RECORD

Surname:	Date of Birth:
First Name:	
Address: Post Code:	

I wish to have access to my medical records online and understand and agree with each statement (tick)	
1. I have read and understood the information leaflet 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. If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible	
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. 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	

Signature:	Date:

For Practice Use Only

Patient NHS Number:		Practice computer ID number:	
Identity verified by (initials)	Date:	Type of Photo ID:	
Authorised by:			Date:
Date Account Created:			
Consultations, lab results, immunisations, & allergies - Retrospective access		Notes/explanation:	
Documents and Free text – Prospective access from 1st April 2020			