Patient Access Application Form

|  |  |
| --- | --- |
| Surname | Date of birth |
| First name |
| AddressPostcode |
| Email address |
| Telephone number | Mobile number |

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

|  |  |
| --- | --- |
| 1. Requesting repeat prescriptions |  |
| 2. Accessing my* Medication
* Allergies
 |  |

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 |  |
| 2. If I choose to share my information with anyone else, this is at my own risk |  |
| 3. If I suspect that my account has been accessed by someone without myagreement, I will contact the practice as soon as possible |  |
| 4. If I see information in my record that is not about me or is inaccurate, I willcontact the practice as soon as possible |  |
| 5. If I think that I may come under pressure to give access to someone elseunwillingly I will contact the practice as soon as possible. |  |

Please attend The Manor Clinic with photo ID such as passport/driving license and proof of address.

Date

Signature