# Carisbrooke Surgery

## Application for online access to my medical record

| Surname | Date of birth |
|---|---|
| First Name | |
| Address | |
| Email address | |
| Telephone number | Mobile number |

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

| | |
|---|---|
| 1. Booking appointments | ☐ |
| 2. Requesting repeat medications | ☐ |
| 3. Accessing my medical record | ☐ |

I wish to have access to my medical record 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. I will contact the Practice as soon as possible if I suspect that my account has been accessed by someone without my agreement | ☐ |
| 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 | ☐ |

| Signature | Date |
|---|---|
| | |

**For practice use only**

| | | |
|---|---|---|
| Patient identity verified by (initials) | Date | Method<br>Photo ID ☐<br>Proof of residence ☐ |
| Authorised by: | Date | Date on-line account created: |
| Level of access to record enabled:<br><br>Booking appointments<br>Repeat Medication<br>Summary Care Record<br>Coded Entries | <br><br>☐<br>☐<br>☐<br>☐ | Date password/user name sent: |