Carisbrooke Surgery

Application for Access to Online Services and Detailed Coded Record

Surname:	Date of Birth:
First Name:	Telephone:
Address:	Mobile:
	Email address:*

*By providing this address you are consenting for it to be used to send or reset your confidential login details.
Please Note: email address and mobile number MUST be unique to you – not shared with other family members for online services to work

Please indicate which service you will be using: **Patient Access** ☐ / **NHS App** ☐ / **Both** ☐

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

- ☐ Booking appointments
- ☐ Requesting repeat medications
- ☐ Accessing my basic medical record (allergies, immunisations, medication)
- ☐ Detailed coded record access

PLEASE NOTE: Access is granted at the discretion of the practice. Your request for access may take up to 28 working days to process. You will be informed if access cannot be granted.

*** Please provide photo ID and proof of address when submitting this form ***

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

☐	I have read and understood the information provided on the website below: https://www.nhs.uk/NHSEngland/thenhs/records/healthrecords/Documents/PatientGuidanceBooklet.pdf
☐	I will be responsible for the security of the information that I see or download
☐	If I choose to share my information with anyone else, this is at my own risk
☐	I will contact the Practice as soon as possible if I suspect that my account has been accessed by someone without my agreement
☐	If I see information in my record that is not about me or is inaccurate, I will immediately log out and report the matter to the Practice as soon as possible
☐	I understand that I may see information on my record that I was unaware of / have forgotten about that could cause distress
☐	I understand that the information may not be a complete record and I should not rely on it for insurance purposes
☐	I understand that online access is granted at the discretion of the practice, taking into account my best interests. I will be informed of any decision to withdraw the service. *Please note, this does not affect your rights of Subject Access under the Data Protection Act.*

Signature	Date

For practice use only

Patient identity verified by *(initials)*	Date	**Photo ID**		**Proof of residence**	
		Driving Licence Passport Other *(please specify)* ……	☐ ☐ ☐	Utility Bill Other *(please specify)* ……	☐ ☐
Authorised by:	Date	Date on-line account created:			