**1 . Application for online access to my medical record- Age 16 and older -** For use for adults requesting access

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

|  |  |
| --- | --- |
| I wish to have access to my detailed coded record from birth and full record from 1.11.23 using online services |  |

I wish to access 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. 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 | | | |
| Identity verified by (initials) | Date | Method  Vouching   Vouching with information in record   Photo ID and proof of residence  | |
| Authorised by | | | Date |
|  | |  | |

***Riverside Health Centre - Manningtree***