# SKEGBY FAMILY MEDICAL CENTRE

## Application for online access to my medical record

| Surname | Date of birth |
|---|---|
| First name | |
| Address<br><br>Postcode | |
| **Email address:**<br>**Please note: Your email address may be used to send confidential data e.g. results, it is not advisable for patients to have the same email address. Please be advised that the practice cannot be held responsible for information sent to a shared email address which has been supplied for more than one patient. Please put your email in block capitals.** | |
| **Telephone number:**<br>**Mobile number:**<br>**Do you consent to contact via SMS text? ☐ Yes** | **Are you a carer? ☐ Yes**<br>**Do you have a carer? ☐ Yes** |

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

| Service | Tick |
|---|---|
| Booking appointments | ☐ |
| Requesting repeat prescriptions | ☐ |
| Limited access to parts of my medical record summary | ☐ |
| Access to detailed coded information | ☐ |

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

| Statement | Tick |
|---|---|
| I have read and understood the information leaflet provided by the practice | ☐ |
| I will be responsible for the security of the information that I see, download, or print | ☐ |
| 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 contact the practice as soon as possible | ☐ |
| I understand some of the entries in my detailed coded record will be made by administrators and not clinical staff, but that the entries have been authorised by a clinician. | ☐ |
| I confirm that the information given on this slip is complete and correct to the best of my knowledge, and that should any of my contact details change I will notify the surgery as soon as this change takes place. | ☐ |
| Signature | Date |

**For practice use only**

| | | |
|---|---|---|
| Patient NHS number | | Practice computer ID number |
| Identity verified by (initials) | Date | Method – Please State<br>Photo ID and proof of residence ☐ |
| Authorised by | | Date |
| Date account created | | |
| Date passphrase sent | | |
| Level of record access enabled<br>Contractual minimum √<br>Other…………………… ……… | | Notes / explanation |