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| The Nuffield Practice |

**Access to GP online services**

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

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

|  |  |
| --- | --- |
| 1. Booking appointments online | 🞏 |
| 1. Requesting repeat prescriptions online | 🞏 |
| 1. Checking test results | 🞏 |
| 1. Accessing my medical record | 🞏 |

# Application for online access to my medical record

I wish to access my medical record online. I understand and agree with each statement as follows: (please tick)

|  |  |
| --- | --- |
| 1. I have read and understood the information leaflet provided by the Practice | 🞏 |
| 1. I will be responsible for the security of information that I see or download | 🞏 |
| 1. If I choose to share my information with anyone else, this is at my own risk | 🞏 |
| 1. I will contact the Practice as soon as possible if I suspect that my account has been accessed by someone without my agreement | 🞏 |
| 1. If I see information in my record that it not about me, or is inaccurate, I will log out immediately and contact the Practice as soon as possible | 🞏 |

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

### For Practice use only

|  |  |  |  |
| --- | --- | --- | --- |
| Identity verified through  (tick all that apply) | Vouching 🞏  Vouching with information in record 🞏  Photo ID 🞏  Proof of residence 🞏 | Name of verifier | Date |