

ALMONDBURY SURGERY

Longcroft, Almondbury, Huddersfield, HD5 8XW

Tel: 01484 514555

Website: www.thealmondburysurgery.co.uk

Application for Online Access to my Medical Record

| | |
|-------------------|----------------|
| Surname: | Date of birth: |
| First name(s): | |
| Address: | |
| Postcode: | |
| Email address: | |
| Telephone number: | Mobile number: |

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

| | |
|--|--------------------------|
| Transactional Services | |
| Booking appointments | <input type="checkbox"/> |
| Requesting repeat prescriptions | <input type="checkbox"/> |
| Record Access – Core Summary Record | |
| Medications and Allergies/Adverse Reactions | <input type="checkbox"/> |
| Record Access – Detailed Coded Record | |
| Lab Results | <input type="checkbox"/> |
| Immunisations | <input type="checkbox"/> |
| Problems | <input type="checkbox"/> |
| Consultations | <input type="checkbox"/> |

I understand and agree with each statement (tick):

| | |
|---|--------------------------|
| I have read and understood the information leaflet(s) provided by the practice | <input type="checkbox"/> |
| I understand that I need to provide Identification with my application, that this will be stored on my medical record and will need to be reproduced when collecting access documents | <input type="checkbox"/> |
| I understand that acceptance is not automatic and that the Practice has the right to remove online services if necessary | <input type="checkbox"/> |
| I will be responsible for the security of the information that I see or download | <input type="checkbox"/> |
| If I choose to share my information with anyone else, this is at my own risk | <input type="checkbox"/> |
| I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement | <input type="checkbox"/> |
| If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible | <input type="checkbox"/> |

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

Application for Online Access to my Medical Record

For practice use only

| | | | |
|--|-------|---|--------------------------|
| Patient NHS number: | | Practice computer ID number: | |
| Identity verified by (initials): | Date: | Method (tick): Vouching <input type="checkbox"/> Photo ID and proof of residence <input type="checkbox"/> | |
| Transactional Services authorised by: | | | Date: |
| Record Access authorised by: | | | Date: |
| Date account created: | | | |
| Services / Access enabled: | | | |
| Transactional Services | | | |
| Booking appointments | | | <input type="checkbox"/> |
| Requesting repeat prescriptions | | | <input type="checkbox"/> |
| Record Access – Core Summary Record | | | |
| Medications and Allergies/Adverse Reactions | | | <input type="checkbox"/> |
| Record Access – Detailed Coded Record | | | |
| Lab Results | | | <input type="checkbox"/> |
| Immunisations | | | <input type="checkbox"/> |
| Problems | | | <input type="checkbox"/> |
| Consultations | | | <input type="checkbox"/> |
| Notes / explanation: | | | |