MEMORIAL MEDICAL CENTRE

Application for online access to my medical record

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

I wish to have access to the following online services (tick):

Booking appointments online, requesting repeat prescriptions and accessing part of my medical record.	

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

I have read and understood the information leaflet provided by the practice	
I confirm that I am aged 16 years or over	
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 contact the Practice as soon as possible	

Signature	Date

For Practice use only

Patient NHS number		Practice computer ID number
Identity verified by Reception Team (Name)	Date	Method (tick) Photo ID (preferable) Bank/credit or NI card Other (please state) Vouching

Authorised by Admin Team	Date
Date account created	

Level of record access enabled Prospective ☐ Retrospective ☐ All ☐ Limited parts ☐ Contractual minimum ☐	Notes / explanation