# Hathaway Medical Practice

## Application for online access to my medical record

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

By filling in this form you will have access to the following online services:

1. **Booking appointments**
2. **Requesting repeat prescriptions**
3. **Accessing your medical record**

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

| | |
|---|---|
| 1. I will be responsible for the security of the information that I see or download | ☑ |
| 2. If I choose to share my information with anyone else, this is at my own risk | ☑ |
| 3. If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible | ☑ |
| 4. 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 (full name +date of birth): | Date |

### For practice use only

| | | |
|---|---|---|
| Patient NHS number | | Practice computer ID number |
| Identity verified by (initials) | Date | Method<br>Vouching ☐<br>Vouching with information in record ☐<br>Photo ID and proof of residence ☐ |
| Authorised by | | Date |
| Date account created | | |
| Date passphrase sent | | |
| Level of record access enabled<br>All ☐<br>Prospective ☐<br>Retrospective ☐<br>Detailed coded record ☐<br>Limited parts ☐ | | Notes / explanation |