Lakenham Surgery
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 **(please tick all that apply):**

Booking appointments	☐
Requesting repeat prescriptions	☐
Limited access to parts of my medical record	☐

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

1. I have read and understood the patient information provided by the practice	☐
2. I will be responsible for the security of the information that I see or download	☐
3. If I choose to share my information with anyone else, this is at my own risk	☐
4. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	☐
5. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible	☐

NB – Please sign this form at the surgery so the receptionist can witness your signature

Signature	Date

For practice use only

Patient NHS number			
Identity verified by	Date	Photo ID (passport/driving licence) ☐ Proof of residence (if passport provided) ☐ (A photocard driving licence will be sufficient providing it quotes your current address)	
Authorised by			Date
Date account created			
Date passphrase sent			
Level of record access enabled Contractual minimum ✓ Other…….. ……			Notes / explanation