

# North Road Suite

■ RAVENSTHORPE HEALTH CENTRE ■

## Application for Access to Online Services & to my Medical Records

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):

1. Booking appointments	<input type="checkbox"/>
2. Requesting repeat prescriptions	<input type="checkbox"/>
3. Accessing my medical record	<input type="checkbox"/>

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

1. I have read and understood the information leaflet provided by the practice	<input type="checkbox"/>
2. I will be responsible for the security of the information that I see or download	<input type="checkbox"/>
3. If I choose to share my information with anyone else, this is at my own risk <b>The Practice recommends that you only do this by granting Proxy access to your account and this is done by requesting this at the Practice – ask our team for details.</b>	<input type="checkbox"/>
4. 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"/>
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	<input type="checkbox"/>

Signature: Print full name:	Date
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### For practice use only

Patient NHS number		Practice computer ID number	
Identity verified by (initials)	Date	Method Photo ID and proof of residence <input type="checkbox"/> <i>(All NRS REGISTRATIONS REQUIRE THE ABOVE)          VOUCHING WILL ONLY BE USED IN VERY LIMITED          CIRCUMSTANCES THIS IS FOR THE PATIENT AND          PRACTICE PROTECTION)</i> Vouching <input type="checkbox"/> Vouching with information in record <input type="checkbox"/>	
Authorised by		Date	
Date account created			
Date password/login details given			
Level of record access enabled		Notes / explanation	
Prospective <input type="checkbox"/> Retrospective <input type="checkbox"/> All <input type="checkbox"/> Limited parts <input type="checkbox"/> (appointment booking only) Contractual minimum <input type="checkbox"/>			

**THIS DOCUMENT NEEDS TO BE SCANNED TO THE PATIENT RECORD AND THEN FILLED IN THE ONLINE A TO Z REGISTRATION FORM FILE.**