Claremont Bank Surgery, Patient Access Request Form

SURNAME	
FIRST NAME	
DATE OF BIRTH	
ADDRESS	
EMAIL ADDRESS	
TELEPHONE (HOME /MOBILE)	

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

1) Booking appointments	☐
2) Requesting repeat prescriptions	☐

Application for online access to my medical record *(AVAILABLE FOR PATIENTS OVER 18 ONLY)*

PLEASE TICK

ALLERGIES ☐ **TEST RESULTS** ☐

IMMUNISATIONS ☐ **PROBLEMS** ☐

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

1) I have read and understood the information leaflet provided by the practice	☐
2) I will be responsible for the security of 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 log out immediately and contact the practice as soon as possible	☐

SIGNATURE:	**DATE**

OFFICE USE ONLY:

Name of person who authorised:			Date:
Identify verified through:	Photo ID: ☐	Proof of residence: ☐	Vouching: ☐