KINGSBRIDGE MEDICAL PRACTICE

APPLICATION FOR ONLINE ACCESS TO MEDICAL RECORDS

Surname			
First Name			
Date of Birth			
Address (including post code)			
E-mail address			
Telephone number		**Mobile number**	

I wish to have access to my medical record online 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 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 log out immediately and contact the Practice as soon as possible	
6. If I have access to my test results I realise that I may see information which I do not understand or may find upsetting	

Signature		**Date**	

For Practice Use Only

Identity verified by (tick all that apply)	Photo Id Proof of Residence Vouching Vouching with information in record	**Name of Verifier:**	**Date**
Application Authorised?	YES NO (delete as appropriate)		**Date**
Name of person who authorised			
Signature of person who authorised			**Date**
Name of person creating account			**Date**
Date passphrase sent to patient			