**The Orchard Surgery**

**Online Medical Records Access: Registration Form**

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| --- | --- | --- | --- | --- |
| **Surname** | **First Name** | | | |
| **Date of Birth** | | | | |
| **Address** | **Post Code** | | | |
| **Email Address** | | | | |
| **Telephone Number** | **Mobile Number** | | | |
| ***I wish to have access to the following online services (please tick all that apply):*** | | | | |
| 1. **Booking Appointments** | | | □ | |
| 1. **Requesting Repeat Prescriptions** | | | □ | |
| 1. **Accessing 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 information leaflet provided by the practice** | | | | □ |
| 1. **I will be responsible for the security of the information that I see or download** | | | | □ |
| 1. **If I choose to share my information with anyone else, this is at my own risk** | | | | □ |
| 1. **If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible** | | | | □ |
| 1. **If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible** | | | | □ |
| 1. **If I think that I may come under pressure to give access to someone else unwillingly I will contact the practice as soon as possible.** | | | | □ |
| **Signature:** | | **Date:** | | |

**Please note:**

* **It will be your responsibility to keep your login details and password safe and secure. If you know or suspect that your record has been accessed by someone that you have not agreed should see it, then you should change your password immediately. Access can also be gained on some phones using fingerprints or Face ID – please consider this.**
* **If you have concerns about this, we recommend that you contact the practice so that they can remove online access until you are able to reset your password.**
* **If you print out any information from your record, it is also your responsibility to keep this secure. If you are at all worried about keeping printed copies safe, we recommend that you do not make copies at all.**
* **The practice may not be able to offer online access due to a number of reasons such as concerns that it could cause harm to physical or mental health or where there is reference to third parties. The Practice has the right to remove online access to services for anyone they feel it could harm or be put at risk.**

*(Page 2 is for Practice Use Only)*

**For Practice Use Only**

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| --- | --- | --- | --- | --- | --- |
| **Patient NHS number** | | **Practice computer ID number** | | | |
| **Identity verified by**  **(initials only)** | **Method Used** | | 1. **Vouching** 2. **Vouching with information in record** 3. **Photo ID and proof of residence** | | □  □  □ |
| **Documentary evidence provided** | | | | | |
| **Authorised by** | | | | **Date** | |
| **Date account created** | | | | | |
| **Date login credentials emailed/given** | | | | | |
| **Level of record access enabled**   1. **Detailed coded report** □ 2. **All prospective** □ 3. **All retrospective** □ 4. **Other limited parts** □ | | | | **Notes / explanation** | |
| **Date clinical assurance completed** | | | | **Assured by (initials only)** | |
| **Reason for refusal if record access is refused after clinical assurance:** | | | | | |