Townsend House
Medical Centre

Application for online access to my medical record

A statutory requirement of online access is that you must supply us with proof of identity. Please see overleaf for a list suitable documents.

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

Surname:	First Name(s):
DOB:	Address: Postcode:
Telephone Number:	Mobile Number:
Email Address:	
I consent to the practice using my mobile telephone number and/or email address to contact me ☐	

Level 1 Access – Booking appointments and Requesting repeat prescriptions	☐
Level 2 Access – Accessing my online medical record **	☐

*** Once the Data Controllers has all the relevant information, your request should be fulfilled within 28 days. (In exceptional circumstances where it is not possible to comply within this period you will be informed of the delay and given a timescale for when your request is likely to be met.)*

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	☐
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. If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible	☐
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	☐
6. 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.	☐
7. I consent for the practice to contact me using either my email or mobile number.	☐

Signature:	**Date:**

For practice use only:

Receptionists please date when form was received and given to doctor:	Date:

Usual GP authorisation **only** if level 2 access is requested – usual GP signature:	Date:
Level of record access enabled: Level 1 – Booking appointments and requesting repeat medication ☐ Level 2 – Online medical records ☐	Entries reviewed by: (for Level 2 access only) Readcode XaE42 added ☐
Account created by:	Date:

Identification documents: (Practice use only)

Driving Licence	Number:	Date of issue:	Date of expiry:
Passport	Number:	Date of issue:	
Bank Statement	Bank Name:	Date of issue:	
Utility Bill	At the discretion of the Practice Manager – Elly Potter: Signed:		
Form taken in by: (Receptionist)			