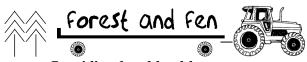
FELTWELL SURGERY



Providing local health care

Application for online access to my medical record

Surname:		Date of birth:	
First name:			
Address:			
		5	
		Postcode:	
Email address:			
Telephone number:		Mobile number:	
I wish to have access to the following online services (please tick all that apply):			
Booking appointments Booking appointments			
2. Requesting repeat prescriptions			
Accessing my medical record			
Living to appear my modical record online and understand and agree with each statement (tigle)			
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			
If I suspect that my account has been accessed by someone without my agreement, I will contact the Practice as soon as possible			
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.			
unwiningly I will contact the I ractice as soon as possible.			
Signature Date			
For Practice use only			
Patient NHS number		Practice computer ID number	
		Tradico dempater is named	
	1		
Identity verified by	Date	Method	
(initials)		Vouch	•
		Vouching with information in rec	
		Photo ID and proof of resider	nce ப
Authorised by		Date	
Date account created		<u> </u>	
Date passphrase sent			
Level of record access enabled		Notes / explanation	
All 🗆			
Prospective □			
Retrospective			
Detailed coded record			
	Limited parts □		