BUDBROOKE MEDICAL CENTRE
Online Access Form
Application for online access to my medical record

Surname Date of Birth
First name
Address
Postcode
Email address
Telephone number Mobile number

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

1 Booking appointments ☐
2 Requesting repeat prescriptions ☐
3 Access to my medical records* (currently you are allowed to view Immunisations, Allergies and Medication) ☐
4 Access to full medical records (from 1st April 2016) ☐

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

1 I have read and understood the '***Guide for patients'*** provided by the practice	
2 I will be responsible for the security of the information that I see, download or print.	
3 If I choose to share the information with anyone else, I do this 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 any information in my record that is not about me, I will log off '**Patient Access immediately** & contact the practice as soon as possible. **I will not download or print any information.**	

Signature Date

For Practice use only:

Patient EMIS computer number

Staff member verified Date (Initials) *Photo ID and proof of residence*

Authorised by *Date*

Level of access enabled *Limited parts* *All*

Read Code	9Rb	Added