

ACADEMY MEDICAL CENTRE

Application form for online access to the practice online services

Surname	Date of birth
First name	
Address	
Postcode	
*(Block Caps)	
*Email address	
Telephone number	Mobile
I wish to have access to the following online services (please tick all that apply):	
1. Booking appointments (currently not available)	<input type="checkbox"/>
2. Requesting repeat prescriptions	<input type="checkbox"/>
3. Accessing my medical record (currently not available in Scotland)	<input type="checkbox"/>
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	<input type="checkbox"/>
2. I will be responsible for the security of the information that I see or	<input type="checkbox"/>
3. If I choose to share my information with anyone else, this is at my own risk	<input type="checkbox"/>
4. If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible	<input type="checkbox"/>
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	<input type="checkbox"/>
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.	<input type="checkbox"/>
Signature	Date
<small>Once a registered patient turns 16 the surgery will require them to confirm current email address or re-register with a new one.</small>	
For practice use only	
Patient NHS number	Practice computer ID number
Identity verified by (initials)	Method used Vouching <input type="checkbox"/> Vouching with information in record <input type="checkbox"/>
Documentary evidence provided	
Authorised by	Date
Date account created	
Date login credentials emailed/given	
Level of record access enabled	Notes / explanation
Detailed coded record <input type="checkbox"/>	
All prospective <input type="checkbox"/>	
All retrospective <input type="checkbox"/>	
Date clinical assurance completed	Assured by (initials)
Reason for refusal if record access is refused after clinical assurance.	