Bottisham Medical Practice

Application for online access to my medical record

Title: Mr / Mrs / Miss / Ms /Dr / Other	First name(s):
Surname:	Sex: Male / female
Date of birth:	Email:
Home address: Postcode:	
Home tel:	Mobile tel:
By providing your mobile number you are agreeing to the practice sending you SMS including, but not limited to Confirmations, Reminders, and other Admin matters. We will also on occasion send SMS with minimal clinical data, please do not provide your number if you do not consent to this.	

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

1. Booking appointments	Yes/No
2. Requesting repeat prescriptions	Yes/No
3. Accessing my medical record	Yes/No

I wish to have access to my medical record online and understand and agree with each statement:

1. I have read and understood the information leaflet provided by the practice	Yes/No
2. I will be responsible for the security of any information that I see or download	Yes/No
3. If I choose to share my information with anyone else, it will be at my own risk	Yes/No
4. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	Yes/No
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	Yes/No
Please note that all statements must be confirmed before online access can be granted.	

Signature of patient:		**Date:**	

FOR PRACTICE USE ONLY

N.H.S Number		
Primary ID seen and signature verified: Passport or Driving License		**Date and initials:**
Secondary ID seen and address verified: A recent Bank Statement or Utility/Council tax bill		
Authorised by:	**Date**	**Date account created and passphrase sent:**
Level of record access enabled: **Prospective** ☐ **Retrospective** ☐ **All** ☐ **Limited Parts** ☐ **Contractual Minimum** ☐	**Notes/explanation**	