|  |  |
| --- | --- |
| Surname | Date of Birth |
| First name(s) |
| Address   | Postcode |
| Email address *(must match patient records)* |
| Mobile number | Landline number |
| **TICK ALL BOXES BELOW TO SHOW YOU’VE READ AND UNDERSTOOD** |
| I wish to have access to my full medical records online. |  |
| I will be responsible for the security of the information that I can see. If I choose to share my information with anyone else, this is at my own risk. |  |
| I understand that I may have test results that seem to be outside the normal range, and that results are affected by things like medication, medical conditions and age, so those results may be in the normal range for me. |  |
| If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible. I will treat any information which is not about me as being strictly confidential. |  |
| I understand that I may see information on my record that I was unaware of / have forgotten about that could cause distress. |  |
| I understand that online access is granted at the discretion of the practice, taking into account my best interests. |  |
| I have photo proof of identity and proof of address as outlined in the information leaflet. |  |
| Signature | Date |
| **FOR PRACTICE USE ONLY** |
| Patient’s EMIS number: | Patient NHS number: |
| **IDENTITY VERIFIED BY**(name) | Date | **RECORD DETAILS OF ITEM*** Photo ID

 * Proof of residence
 | Copies taken for scanning by (*name*) |
| IGPR Completed by (*if full access)* | Date Checked |
| GP authorisation | Date Authorised |
| Date Access Given |

Patient Requesting *(please circle)*

|  |  |  |
| --- | --- | --- |
| Full Access | Partial Access | Other (*please state)* |