# Ainsdale Medical Centre

**F**

## (Form F) Application for online access to detailed record

**(For new and existing users of Patient Access)**

| | |
|---|---|
| **Surname :** | **Date of birth : / /** |
| **First name** | |
| **Address:**<br><br>**Postcode :** | |
| **Email address :** | |
| **Telephone number :** | **Mobile number :** |
| **Are you an existing user of Patient Access on-line services? Yes ☐ No ☐** | |

I wish to access my medical record online and understand and agree with each statement (tick each box) I want to be able to book appointments, order repeat medication and have detailed access to coded items in my medical record including medication, consultations and test results.

| | |
|---|---|
| 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 | ☐ |
| 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 information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible. | ☐ |
| 6) If I do see information about another person, whether I know them or not, I will not discuss the details with anyone other than a member of practice staff. | ☐ |
| 7) I understand that the GP has to review my medical record and may refuse access if, in their reasonable opinion, access to such information may not be in my best interests. | ☐ |

| | |
|---|---|
| **Signature:** | **Date: / /** |

**For practice use only (code to 9RN)**

| | | |
|---|---|---|
| **Record of ID provided ( 1 photo; 1 address)** | Checked | Checked by:<br><br>Date: |
| ID 1. _____ | ☐ | |
| ID 2. _____ | ☐ | Counter-signed by:<br><br>Date: |
| Notes | | |

Scan page to patient record: Source = “9RN”, type = “On-line access”. Do not workflow to doctor