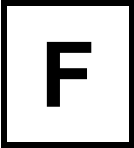


# Ainsdale Medical Centre



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

(For new and existing users of Patient Access)

<b>Surname :</b>	<b>Date of birth :</b> /    /
<b>First name</b>	
<b>Address:</b>	
<b>Postcode :</b>	
<b>Email address :</b>	
<b>Telephone number :</b>	<b>Mobile number :</b>
<b>Are you an existing user of Patient Access on-line services?    Yes <input type="checkbox"/>    No <input type="checkbox"/></b>	

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	<input type="checkbox"/>
2) I will be responsible for the security of the information that I see or download	<input type="checkbox"/>
3) If I choose to share my information with anyone else, this is at my own risk	<input type="checkbox"/>
4) I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	<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 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.	<input type="checkbox"/>
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.	<input type="checkbox"/>

<b>Signature:</b>	<b>Date:</b> /    /
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**For practice use only (code to 9RN)**

<b>Record of ID provided ( 1 photo; 1 address)</b>	<b>Checked</b>	<b>Checked by:</b>
ID 1. _____	<input type="checkbox"/>	Date:
ID 2. _____	<input type="checkbox"/>	Counter-signed by:
		Date:
<b>Notes</b>		