# Southlands Medical Group

**Application for online access to my medical record**

|  |  |
| --- | --- |
| Surname | Date of birth |
| First name | |
| Address  Postcode | |
| Email address | |
| Telephone number | Mobile number |

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

|  |  |
| --- | --- |
| 1. Access to my medical record (tick all you require access to): | |
| Adverse reactions/Allergies   | Medication  |
| Immunisations  | Problems  |

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 |  |
| 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 |  |
|  |  |

**Signature: Date:**

***By signing this document I understand that the practice reserves the right to deny my access to my medical records should they feel it would be in breach of Information Governance regulations***

# For practice use only

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Demographic details verified: YES / NO  Checked against computer details: YES / NO | | EMIS number: | | |
| Identity verified by Name: | Date | Method  Photo ID and proof of residence   Vouching   Vouching with information in record  | | |
| Access Authorised by (Practice Manager or GP Partner only) | | | | Date |
| Date access created | | | | |
| Date passphrase sent | | | | |
| Level of record access enabled:  Adverse/Allergic reactions   Medication   Immunisations   Problems  | | | Notes / explanation | |

V1 - June 2015