Helmsley Medical Centre

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Application for online access to my medical record

Surname	Date of birth
First name	
Address INCLUDING POST CODE please	
Email address	
Telephone number	Mobile number

I wish to have access to REQUESTING REPEAT PRESCRIPTIONS ONLINE ☐

I 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

For practice use only

Staff please initial here when ID checked	**Date**	**How did you check?** **☐ Vouching – patient known to you** **☐ Vouching - with information in record** **☐ Photo ID and proof of residence seen**
Date account created & passphrase prepared		Date
Signed by Staff		
Level of record access enabled Prescription Requests only ☐		Notes / explanation