Request for Online Access to Medical Records Form

Thank you for your request to access your medical records online. In order to protect patient confidentiality and to follow best practice we require all patients wishing to gain access to their medical records online to return this complete request form to our reception team in person along with a valid form of photo ID.

First Name ____________________________ Surname ___________________________________

Date of birth ______________ Full Address ____
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Home Telephone _____________________________ Mobile Telephone ____________________________

Email Address ____

Statements

Abnormal Results, Bad News or Forgotten History

By having online access to your medical record you may see something that you find upsetting or that you have forgotten and this may occur before you have spoken to your doctor or outside of surgery opening hours when you cannot contact your GP.

Choosing to Share Your Information and Coercion

You have the choice to share your medical record with others. It is your choice, but also your responsibility to keep your information safe. If you feel pressured into revealing details from your medical record to someone else against your will it may be best not to register for online access.

Misunderstood information

Your medical record is used by clinical professionals and written by specialists. This information is often technical and not easily understood. If you require clarification about an item in your medical record please contact the surgery for a clearer explanation.

Declarations

(Please tick each declaration to show you understand and agree with them, online access to your record may not be granted if you do not agree with these declarations).

1. I have read and understood the information on this form. ☐
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 someone else has accessed my account without my consent. ☐
5. If I see information on my account which is not about me, or is inaccurate, I will log out immediately and contact the practice as soon as possible ☐

Signature ____ Date _________________

For Practice Use Only

Identify Verified through	Vouching ☐ Photo ID ☐ Proof of residence ☐	Name of Verifier	Date