Wallingford Medical Practice
Application for Advanced online access to my medical record

By completing this form I confirm I would like access to my medical record online. I have read and understand the Practice information leaflet, which I can get from reception in surgery or Online at www.wallingfordmedicalpractice.co.uk. By signing the form I adhere to use the system responsibly in accordance with all instructions given to me by my GP practice. I agree to inform my GP practice of any errors /problems I see within my record whilst I use the system.

Surname:	**First Name:**
Date of Birth:	**NHS no (if known):**
Address:	
Email:	*By giving your email you are consenting to be contacted by email*
Home Telephone:	**Mobile:**

Is this application for you?

☐ Yes ☐ No, if no please state below who it is for and the relationship.

_____

Please Note - Access cannot be given for anyone aged 11 – 16 years. If you have any questions regarding this please contact the surgery and speak to Debra Perry/Andrew Knight

All applications are to be reviewed by a GP and should the application be deemed invalid, you will be contacted regarding this and the reason why. Access can take up to 20 days to be processed.

By completing this form you are asking for access to the following online services -

Booking Appointments

Requesting repeat prescriptions

Changing my contact information

Accessing my medical information

Should you only wish to view booking appointments, requesting repeat medication and changing your contact information (basic access) please complete the online form for basic access which can be found on our website or you can ask reception.

I confirm I have read the information leaflet provided by the surgery and agree to be responsible for the security of the information that I see or download. I understand that if I choose to share my information with anyone else, this is at my own risk. I understand that I should contact the practice as soon as possibly if I suspect my account has been accessed without my permission or unlawfully. I understand I will contact the practice should I see information that is not about me or is incorrect.

Signed:_____ Name(printed):_____

Practice use only

Identity verified by: Method: Vouching/Photo ID & proof of address (please delete)

ID Seen: Passport/driving license/Bank statement/Utility Bill (please delete as appropriate)

Authorised by: Date: