RAINBOW MEDICAL CENTRES

Application for online access to my medical record

Surname	Date of birth
First name	
Address Postcode	
Email address (which will be used for online access & replace any already recorded by the practice)	
Telephone number	Mobile number

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

1. Booking appointments	☐
2. Requesting repeat prescriptions – in order to use this service please tell us who your nominated pharmacy is – My nominated pharmacy is :	☐
3. Accessing my medical record	☐

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

For practice use only

Patient NHS number		Practice computer ID number	
Identity verified by (initials)	Date	Method Vouching ☐ Vouching with information in record ☐ Photo ID and proof of residence ☐	
Authorised by			Date
Date account created			
Date passphrase sent			
Level of record access enabled Prospective ☐ Retrospective ☐ All ☐ Limited parts ☐ Contractual minimum ☐			Notes / explanation