Lancaster Medical Practice

LANCASTER MEDICAL PRACTICE

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 access the following online services (please tick all that apply):

1. Booking appointments ☐
2. Requesting repeat medication ☐
3. Accessing my medical record (over 16's only) ☐

I understand and agree with each of the following statements (please tick):

a. I have read and understand the information leaflet provided by the practice ☐
b. I will be responsible for the security of the information that I see or download ☐
c. If I choose to share my information with anyone else, this is at my own risk ☐
d. I will contact the practice immediately if I suspect my account has been accessed without my agreement ☐
e. If I see information in my record that is not about me or is inaccurate, I will contact the practice immediately ☐

I confirm that I am the patient detailed or requesting on their behalf. If requesting for a child, please note that the child will need to sign their own request form when they reach 13 years of age (you will be sent a letter regarding this nearer the time)

Signature	Date
Name of Parent or Guardian if patient is under 13	Relationship to child

For practice use only – Reception Staff

Patient NHS number		Practice computer ID number
Identity verified by (initials)	Date	Method Driving Licence ☐ Passport ☐ Other photographic ID ☐ _____ Proof of residence / utility bill within last 12 months ☐ Type: _____