**DINNINGTON GROUP PRACTICE**

**Online Access to Medical Records Application Form**

|  |  |  |  |
| --- | --- | --- | --- |
| **SystmOne Access 🞏** | **Rotherham App Access 🞏** | | **Both 🞏** |
| Surname | | Date of birth | |
| First name | | | |
| Address    Postcode | | | |
| Email address | | | |
| Telephone number | | Mobile number | |

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

|  |  |
| --- | --- |
| Booking appointments | 🞏 |
| Requesting repeat prescriptions | 🞏 |
| Access to my detailed coded medical record | 🞏 |
| Access to my full clinical record from the date of this application | 🞏 |

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 | 🞏 |
| 1. I will be responsible for the security of the information that I see or download | 🞏 |
| 1. If I choose to share my information with anyone else, this is at my own risk | 🞏 |
| 1. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement | 🞏 |
| 1. 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 | |  | |
| Identity verified by  (Name) | Date | Method  Vouching 🞏  Vouching with information in record 🞏  Photo ID 🞏  Proof of residence 🞏 | |
| Authorised by | | | Date |
| Date account created | | | |
| Date Account Denied | | Notes / explanation | |