**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 | MethodVouching 🞏Vouching with information in record 🞏 Photo ID 🞏Proof of residence 🞏 |
| Authorised by  | Date |
| Date account created  |
| Date Account Denied | Notes / explanation |