**Almondsbury Surgery - Application for online access to my medical record**

Please note: An email address (for each individual) is required to have online access.

|  |  |
| --- | --- |
| **Surname** |  |
| **Forename(s)** |  |
| **Date of birth** |  |
| **Address** |  |
| **Postcode** |  |
| **Email Address (cannot be shared email)** |    |
| **Home Tel** |  |
| **Mobile Tel** |  |

**I wish to have access to the following online services (please tick all that apply). *Please note you are only allowed to book appointments for yourself. Additional family members need their own login.***

|  |  |
| --- | --- |
| **Booking appointments** |  |
| **Requesting repeat prescriptions** |  |
| **Accessing my medical record \*** |  |

\*If you require access to more information, this has to be in discussion with a GP. Please ask at reception or view online.

**I wish to access my medical record and understand and agree with each of the following statements (please tick).**

|  |  |
| --- | --- |
| I have read and understood the information leaflet provided by the practice |  |
| I will be responsible for the security of the information that I see or download |  |
| If I choose to share my information with anyone else, this is at my own risk |  |
| I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement |  |
| If I see information in my record that is inaccurate, I will contact the practice as soon as possible |  |

|  |  |
| --- | --- |
| Signature | Date |

**Signing gives your express consent to use personal information on this form in accordance with General Data Protection Regulations (GDPR) effective from 25 May 2018**

**Electronic prescribing is fast and accurate and saves GP time. As you are ordering your medication online, it makes sense for the prescription to go direct to a pharmacy of your choice following electronic signing by a GP.**

**Please nominate your pharmacy………………………………………………………….**