THE MORRIS HOUSE GROUP PRACTICE

Application for online access to my medical record
(Please complete in black ink in BLOCK capitals)

Surname:	Address:
First Name:	
Date of Birth:	
Tel No:	
Mobile No:	
Email Address:	
@	

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

Booking appointments	☐
Requesting repeat prescriptions	☐
Accessing my medical record	☐

I wish to access my medical record online and understand and agree with each statement (*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 not about me or is inaccurate, I will contact the practice as soon as possible	☐
I agree that the practice may contact me by email in relation to my medical matters	☐

Signature: _____ Date: _____

For Practice use only

Identity verified by:		NHS number:	
Method:		Date:	
Vouching	☐	Registration Data Verified - #91B	☐
Vouching with information in record	☐	Free text form of ID entered	☐
Photo ID and proof of residence	☐		

Authorised by:	Date account created:	
Date:	Date pass-phrase sent:	
Vision ID:	Notes summary verified by clinician - #93440	☐