Littleborough Group Practice

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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 have access to the following online services (Please tick all that apply)

1. Booking Appointments	☐
2. Requesting repeat prescriptions	☐
3. Accessing my medical record	☐

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	☐
2. I will be responsible for the security of the information that I see or download	☐
3. If I choose to share my information with anyone else, this is at my own risk	☐
4. I will contact the Practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	☐
5. 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		
Identiity verified by (initials)	Date	Method Vouching ☐ Vouching within information in record ☐ Photo ID and proof of residence ☐