## **SPENCER STREET SURGERY**

## **Application for online access to my medical record**

Surname		Date of b	rth		
First name		1			
Address					
		Postcode			
Email address					
Telephone number		Mobile nu	Mobile number		
		. , ,			
I wish to have access to the following online services (please tick all that apply):					
Booking appointments     Requesting report properties.					
<ol> <li>Requesting repeat prescriptions</li> <li>Accessing my medical record</li> </ol>					
5. Accessing my medical record					
I wish to access my medical	record online and	understand and	agree with each statement (1	tick)	
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			on 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					
contact the practice	e as soon as po	SSIDIE			
Signature			Date		
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Signature  For practice use only			Date		
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