ST JOHNS MEDICAL CENTRE

Application: Online access to a summary of my medical record

SURNAME:	DATE OF BIRTH:
FORENAMES:	
ADDRESS:	
EMAIL ADDRESS:	
TELEPHONE NUMBER:	MOBILE NUMBER:

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

1. Requesting repeat prescriptions	
2. Test results	
3. Immunisation history	
4. Documents	
5. Medical record: Start date -	

I wish to access my medical record online. I understand and agree with each statement (please tick each box you agree with).

1. If I choose to share my information with anyone else, this is at my own risk.	
2. I will contact the Practice as soon as possible if I suspect that my account has been accessed by someone without my agreement.	
3. 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:

To be completed by St Johns staff:

Patient NHS Number:			
Identity verified by:	Date:	Method	
		⇒ ID seen	
		⇒ Vouching	
Authorising Dr:			
Date account created:			
Date registration form sent:			