Oak Glen Surgery

Application for online access to my medical record

Surname:	Date of birth:
First Name:	
Address:	
Email:	
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 records online and understand and agree with each statement (please tick all)

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