Ash Trees Surgery

Ash Trees Surgery - Full Medical Record Access

****Please note - this form is only applicable if you already have an existing Patient Access account****

Application for online access to my full medical record - This form is to be completed if you wish to have access to your full medical record. By completing this form, you are asking us to make your information we hold in Practice available to you securely over the internet. Your information will not be made available without your permission. If you decide to withdraw it, it will not affect your treatment in any way.

Name:	
Former Names:	
Date of Birth:	
Address:	
Email Address:	
Contact number:	

Please read the following before completing the statements below:

1. **Forgotten history**—There may be something you have forgotten about which could cause distress.
2. **Abnormal results/bad news**— You may see this before you have spoken to the Doctor, or while the surgery is closed and you cannot contact them
3. **Coercion**— If you think that you may come under pressure to give access to your record to someone else unwillingly at any time, please reconsider using this service. Please inform a member of the Practice teams as soon as possible if this is the case.
4. **Errors in your Record**— In this case please contact the surgery to enable us to correct your record

Application for online access to my medical record (Detailed Coded Data)

I wish to access my medical record online, and understand and agree with each statement (please 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 log out immediately and contact the Practice as soon as possible		☐
6. If I feel I am being coerced into revealing details from my record, I shall contact the surgery to remove this access		☐
7. I understand it may take up to 40 days to activate access		☐
Signature:	Date:	

For Practice use only	*Identity verified through (tick all that apply):*	*Name of Verifier:*	*Date:*
Statements 1-7 highlighted ☐	Either passport or driving licence ☐ Number: ______ ______ *OR* Two documents providing proof of Residence ☐		
Date account created:	*EMIS Number:*		