Application for Retrospective online access

Patients aged 16 and over

Surname	Date of birth
First name	
Address Postcode	
Email address	
Telephone number	Mobile number
I wish to have access to the additional online services (please tick):	
Accessing my medical record (Retrospective)	☐

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		Practice computer ID number	
Identity verified by (initials)	Date	Method **ID not verified (access already granted)** ☐ Vouching ☐ Photo ID and proof of residence ☐	
Authorised by		Date	
Record Access updated on (Date)			
Record Access from (Date)			
Level of record access enabled Prospective ☐ **Retrospective** ☐ All ☐ Limited parts ☐ Contractual minimum ☐		Notes / explanation	