Crown Heights Medical Centre

Application for Access to Medical Record Online

****For patients over the age of 16 only**

Surname: *	Date of birth: *
First name: *	
Address *	
Email address:	
Telephone number	Mobile number

I wish to have access to my medical records online and understand and agree with each statement

I have read and understand the information leaflet provided by the practice	☐
I will be responsible for the security of the information that I see or download	☐
If I choose to share my information with anyone else, this is at my own risk	☐
I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	☐
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 (The registration letter will be posted to the patient)

Identity verified by*	Date*
Official Photographic I.D is required for online access to medical records. Detail type of I.D seen *	
Authorised by GP (only for access to medical records)	Date
Date letter(s) sent	
Notes:	