The James Cochrane Practice

Patient Access to Full Record Access to Online Services - Identity Verification

By completing this form you are asking 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.

Surname			
First name			
Date of birth			
Address			
Postcode			
Email address			
Telephone number		Mobile number *(if applicable)*	

Please note: you MUST complete all sections above to register for online access to your medical record

Please tick if you are happy to receive communication from the Practice via text message *(on the mobile phone number indicated above)* 9NDP	☐
Please tick if you are happy to receive communication from the Practice via Email *(on the Email address indicated above)* 9NDS	☐

Application for online access to my medical record

Please read the following before completing the statements:

1. Coercion – if you think you will be pressured into revealing details from within your record to someone else, against your will, please reconsider using this service
2. Errors in your record – in this case please contact the surgery to enable us to correct your record

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	☐

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Patient Confirmation

I confirm that the details outlined above are a true and accurate representation.

Signature:		Date:	
Relationship to patient: *(if applicable)*			

Identity Verification *(Practice Use Only)*

Vouching means confirming that you personally recognise a patient, for example, if the patient has been registered at your organisation for a long time.

Identity verified by: (please tick)	Vouching		Name of person vouching for this patient:		Date:
	Documentation		Document 1:	Document 2:	Date:
Date account created:					
Date pass phrase sent:					
Emis number:					
Registration completed by: (staff name)					

Please ensure that this completed form is scanned and saved into the patient record with the read code 9RN.

Application for Proxy Access *(Practice Use Only)*

Consent form received:	Yes / No	Consent form attached:	Yes / No
Access granted to: (name)		Relationship to patient:	
Identity verified by Documentation:	Document 1:	Document 2:	Date:
Date account created:			
Date pass phrase sent:			
Emis number:			
Registration completed by:(staff name)			