Northdown Surgery
Dr J Geevarghese
Dr J Murtinho-Braga
Dr M Wolny

Request for Online Access to my medical record

Surname	Date of birth
First name	
Address Postcode	
Email address (compulsory field)	
Telephone number	Mobile number

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	☐
6. I enclose the necessary compulsory photo ID required	☐
7. I enclose the necessary compulsory recent proof of address, bill, statement etc.	☐

Signature	**Date**

For practice use only

Patient NHS number:		EmisWeb number:	
Identity verified by: *Please print name*	Date:	Method of ID Photo ID and recent proof of residence ☐ ID and recent proof of residence ☐ Vouching ☐ Vouching with information in record ☐	
Access given by:		Date	