

## Application for online access to my medical record (Young People aged 13 - 15)

<b>Surname</b>			
<b>First name</b>			
<b>Date of birth</b>			
<b>Address</b>			
<b>Postcode</b>			
<b>Email address</b>			
<b>Telephone number</b>		<b>Mobile number</b>	

### If you wish to have your own online access - Please complete this section

I wish to have access to the following online services (tick all that apply):

- Booking appointments
- Requesting repeat prescriptions
- Accessing summary record
- Accessing my read coded medical record

Online login details

- I wish to have my login details posted to me
- I wish to collect my login details from the surgery (please allow 14 days)

### If you wish your parent/ guardian to have access on your behalf - Please complete this section

Contact details of authorized person

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

I wish the above named person to have access to the following online services (tick all that apply):

- Booking appointments
- Requesting repeat prescriptions
- Accessing summary record
- Accessing my read coded medical record

**I have read and understood the information in the booklet**

<b>Signature</b>		<b>Date</b>	
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### For practice use only

Identity verified through (tick all that apply)	<input type="checkbox"/> Vouching <input type="checkbox"/> Proof of residence <input type="checkbox"/> Driving Licence <input type="checkbox"/> Passport <input type="checkbox"/> Bus Pass <input type="checkbox"/> Other	Name of verifier	Date
Name of person who authorised			Date