Bournbrook Varsity Medical Centre

**1A Alton Road, Selly Oak, Birmingham B29 7DU**

**Tel: 0121 472 0129**

***Open Monday to Saturday***

***Dr C Allen, Dr M Swallow, Dr A Dungate, Dr S Clarke - Partners***

***Dr M Philp, Dr A Nijjar, Dr H Cole, Dr S Ali, Dr J Tatlock, Dr N Ahmad, Dr N Grant, Dr H Sukkar - Associates***

**Online Medical Records Access:**

**Adult Registration Form**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Surname** | **First Name** | | | |
| **Date of Birth** | | | | |
| **Address** | **Post Code** | | | |
| **Email Address** | | | | |
| **Telephone Number** | **Mobile Number** | | | |
| *I wish to have access to the following online services (please tick all that apply):* | | | | |
| 1. **Booking Appointments** | | | □ | |
| 1. **Requesting Repeat Prescriptions** | | | □ | |
| 1. **Accessing my Medical Record** | | | □ | |
| *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** | | | | □ |
| 1. **I will be responsible for the security of the information that I see or download** | | | | □ |
| 1. **If I choose to share my information with anyone else, this is at my own risk** | | | | □ |
| 1. **If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible** | | | | □ |
| 1. **If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible** | | | | □ |
| 1. **If I think that I may come under pressure to give access to someone else unwillingly I will contact the practice as soon as possible.** | | | | □ |
| **Signature:** | | **Date:** | | |

*(Page 2 is for Practice Use Only)*

**For Practice Use Only**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Patient NHS number** | | **Practice computer ID number** | | | |
| **Identity verified by**  **(initials only)** | **Method Used** | | 1. **Vouching** 2. **Vouching with information in record** 3. **Photo ID and proof of residence** | | □  □  □ |
| **Documentary evidence provided** | | | | | |
| **Authorised by** | | | | **Date** | |
| **Date account created** | | | | | |
| **Date login credentials emailed/given** | | | | | |
| **Level of record access enabled**   1. **Detailed coded report** □ 2. **All prospective** □ 3. **All retrospective** □ 4. **Other limited parts** □ | | | | **Notes / explanation** | |
| **Date clinical assurance completed** | | | | **Assured by (initials only)** | |
| **Reason for refusal if record access is refused after clinical assurance:** | | | | | |