

The Lyndhurst Surgery
53 Lyndhurst Drive, Leyton, London, E10 6JB

Application for Patient Services
Appointments/Repeat Prescriptions/Access to Medical Records
THIS SERVICE IS NOT AVAILABLE TO PATIENTS AGED UNDER 16

PROOF OF ADDRESS (NOT MORE THAN 3 MONTHS OLD) AND PHOTOGRAPHIC
PROOF OF ID MUST BE SUBMITTED WITH THE APPLICATION FORM

| | |
|-------------------------------|----------------|
| Surname: | Date of Birth: |
| First Name: | |
| Address (including postcode): | |
| Email Address (please print): | |
| Home Telephone Number: | Mobile Number: |

| | | |
|--|---|-------------|
| I wish to have access to the following online services (please tick all that apply): | | Tick |
| 1. | Booking appointments | |
| 2. | Requesting repeat prescriptions | |
| 3. | Accessing my Online Summary - FORM MUST BE SUBMITTED BY APPLICANT IN PERSON | |
| 4. | Accessing my Detailed Coded Record - FORM MUST BE SUBMITTED BY APPLICANT IN PERSON | |

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

ALL BOXES MUST BE TICKED

| | | |
|----|--|-------------|
| | | 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. | |

ACCESS TO THE ONLINE SUMMARY/DETAILED CODED RECORD WILL NOT BE GIVEN UNTIL THE PATIENT'S USUAL GP HAS GIVEN HIS/HER AUTHORISATION

NEW PATIENTS WILL NOT BE GIVEN ACCESS TO THEIR MEDICAL RECORDS UNTIL THEIR PREVIOUS MANUAL MEDICAL RECORDS HAVE BEEN RECEIVED AND SUMMARISED

| | |
|----------------------|-------|
| Patient's Signature: | Date: |
|----------------------|-------|

For Practice use only

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|---|---|
| Patient's NHS Number: | Vision ID: |
| Identity verified by (name): | Details of proofs submitted: |
| Date: | Photo ID: |
| | Proof of Address: |
| Date account created: | |
| Date below Read Code added to patient's medical record: | |
| Patient has online access to primary care medical record | |
| Access to Online Summary Authorised by: | Date: |
| Access to DCR Authorised by (GP): | Date: |
| Level of record access enabled (tick below): | |
| All <input type="checkbox"/> Documents <input type="checkbox"/> Problems <input type="checkbox"/> | Test Results <input type="checkbox"/> Immunisations <input type="checkbox"/> Consultations <input type="checkbox"/> |
| Notes | |

| | |
|--|--|
| Date patient informed about registration details: Read code (Email sent to patient) added to patient's records Read code (Patient has online access to primary care medical record) Please mention which access has been given | |
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