BETHESDA MEDICAL CENTRE

Application for Access to Online Services

Via Patient Access APP

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Full Name of Patient			
Date of Birth	Address		
Email address	<u> </u> -		
Endi dadi ess	Doct Code		
Contact Number	Post Code		
If applicable please fill in the following			
I am a Parent/Carer for a child under 16 years old. I understand that once the applicant reaches 16 years of age, they will need to re-apply independently for online access.			
I have Power of Attorney for my relative and would like to request access to their detailed care record.			
Name of requestor if not the patient:		Relationship with patient:	
I wish to have access to the following online services (tick)			
Accessing Medical Records and Electronic prescribing online – Via Patient Access App			
☐ To book appointments online (unfortunately this service is currently unavailable)			
☐To request prescriptions online			
□Core summary record (access to brief record summary, current medication and allergy information)			
□ Laboratory test results			
□Documents			
□Immunisations			
□Problems			
☐ Consultations			
I wish to access my medical record online and understand and agree with each statement (tick)			
☐ The information I want access to is Personal Information and Highly Confidential			
☐ I will be responsible for the security of the information that I see or download			
\square If I choose to share my information with anyone else, this is at my own risk			
☐ If I suspect that my account has been accessed by someone without my agreements, I will contact the practice as soon as possible			
☐ If I change my mind as to who can have access to my information, I will inform the surgery			
Signature of requestor:			
Please provide Photo Identification and confirmation of address (dated within three months). Your application will not be			
processed without this information.			
Office Use Only			
Staff Signature to confirm ID/POA seen		Date	
Authorised by		Date	