THE RED PRACTICE
WALTON HEALTH CENTRE

Application for online access to records of a patient under 11 years of age

Details of person seeking access:

Surname:	Date of birth:
First name:	
Address: Postcode:	
Email address:	
Telephone number:	Mobile number:

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

1. Booking appointments	
2. Requesting repeat prescriptions	
3. Accessing my medical record	

I …….. wish to have online access to the services ticked in the box above for …… (name and date of birth of patient).

I understand my responsibility for safeguarding sensitive medical information and I understand and agree with each of the following statement:

1. I have read and understood the information leaflet provided by the practice and agree that I will treat the patient information as confidential	
2. I will be responsible for the security of the information that I see or download	
3. I will contact the practice as soon as possible if I suspect that the account has been accessed by someone without my/our agreement	
4. If I see information in the record that is not about the patient, or is inaccurate, I will contact the practice as soon as possible. I will treat any information which is not about the patient as being strictly confidential	

Signature:	Date: