The Cambridge Practice

Aldershot Centre for Health
Hospital Hill, ALDERSHOT, GU11 1AY

Tel: 01252 344868
Fax: 01252 335420

email: thecambridge.practice@nhs.net
www.cambridgepractice.co.uk

ONLINE RECORD ACCESS ENROLMENT FORM

You can now use the internet to securely view your test results, your medical history, including current and past medication. Whether you want to improve your knowledge of your medical condition, or check your record for accuracy – it's at your fingertips when you need it. You can even access it from anywhere in the world if you need medical treatment on holiday.
By completing this form you are asking us to make information from GP records available to you, securely over the internet. Your information will not be made available without your permission. If you decide not to join, or wish to withdraw, it will not affect your treatment in any way.

Things to Consider:
Although the chance of the following things happening is very small, please read and tick the boxes to confirm that you have understood:

1. Forgotten History -
There may be something you have forgotten about that could cause distress. ☐

2. Abnormal Results/Bad News -
You may see this before you have spoken to the doctor, or while the surgery is closed and you cannot contact them. ☐

3. Coercion -
If you think you will be pressured into revealing details from within your record to someone else, against your will, please reconsider using this service. ☐

4. Errors in your Record -
In this case please contact the Surgery to enable us to correct your record. ☐

5. NHS App -
Have you downloaded and accessed the NHS app. ☐

PLEASE COMPLETE IN BLOCK CAPITALS

SURNAME	
FIRST NAME	
DATE OF BIRTH	

Dr Claire BROOKS MB ChB MRCGP
Dr Stephen SCOTT-PERRY BMSc(Hons) MB ChB DRCOG MRCGP
Dr Karen ROBINSON BSc(Hons) MB BS DCH DFSRH MRCGP
Dr Peter BIBAWY MBBch MRCGP

Dr Alex SAUTELLE MB BS MRCGP
Dr A Elizabeth WALKER MB ChB MRCGP DCH DRCOG
Dr Nelly KING MRCGP
Dr Lesley ROSLING MB BS DCH MPH MRCGP

Branch Surgery:
276 Lower Farnham Road
ALDERSHOT, GU11 3RB

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ADDRESS	
POST CODE	
EMAIL ADDRESS	
TELEPHONE NUMBER	

I wish to access my medical record online and understand and agree with each statement (Please tick)

I will be responsible for the security of the information that I see or download	
If I choose to share my information with anyone else, that is at my own risk	
I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	
If I see information in my record that is not about me, or is inaccurate I will log out immediately and contact the practice as soon as possible	

I agree that by completing this form I have read and understood 'Things to Consider' above:

SIGNED			
PRINT NAME		**DATE**	

If you are enrolling on behalf of someone else, please provide the following information:

SIGNED			
PRINT NAME		**DATE**	
Do you have authority to access their medical record?	**Yes / No**		
Relationship to Patient			

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FOR PRACTICE USE ONLY

Identity Verified (Tick all that apply)	*Name of Verifier*	*Date*
Vouching ☐ *Vouching with info in record* ☐ *Photo ID*		
Name of person authorised to create account		*Date*
Date Account Creation		
Date of Passphrase Sent		