**Request to Supply Patient with Linkage Key / Passphrase for**

**Active Existing Systmone online Service User**

|  |  |  |
| --- | --- | --- |
| Surname | | Date of Birth |
| First name | | NHS No |
| Address | | |
|  | Postcode | |
| Email address | | |
| Telephone Number | | Mobile Number |
| Consent to receiving text messages Yes/No | |  |

By completing and signing this form you are confirming that you wish to be given the linkage key / passphrase

For you to pass to a third party to be used to link the third party to your medical record

|  |  |
| --- | --- |
| Signature | Date |

**For practice use only**

|  |  |  |  |
| --- | --- | --- | --- |
| Identity verified by  (Full Name & Position) | Date | Method Please Choose below | |
| Vouching personally |  |
| Vouching with information in record |  |
| Photo ID and proof of residence  **Please specify what document/s you have seen as proof of ID:** |  |
| Authorised by:  Name  Position | | Date Linkage Key / Passphrase Given to Patient : | |