**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:NamePosition  | Date Linkage Key / Passphrase Given to Patient : |