

**Application for Online Access**

|  |  |
| --- | --- |
| Surname | Date of Birth |
| First Name | |
| Address  Postcode | |
| Preferred Email address |  |
| Telephone number | Preferred 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 Online Summary (Medications and Allergies) |  |

**I wish to use Online Services. Please read each statement carefully and tick before signing.**

|  |  |
| --- | --- |
| a. I have read and understood the information leaflet provided by the practice |  |
| b. I will be responsible for the security of the information that I see or download |  |
| c. If I choose to share my information with anyone else, this is at my own risk |  |
| d. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement |  |
| e. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible. |  |

**I understand and agree with all the above statements:**

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

**For practice use only**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Patient NHS Number | | |  | | | | |
|  | |  | | |
| Identity verified by (initials) | Date | Method  Vouching  Vouching with information in record  Photo ID and proof of residence | | | | | |
| Authorised by | | | |  | | Date | | |
| Date account created | | | | | | | |
| Date registration letter created | | | | | | | |
| Level of record access enabled (eg 1-4 above) | | | | | | |

|  |  |
| --- | --- |
| Signature On Collection of details | Date Collected |
| …………………………………………………………… |  |