Application for online access for patients (over 11)

SURNAME	D.O.B
FIRST NAME	
ADDRESS	
EMAIL ADDRESS	
TELEPHONE NUMBER	MOBILE NUMBER
I wish to access to the following online services (please tick all that apply)	
1. Booking appointments	
2. Requesting repeat prescriptions	
3. Receive Text Messages	
I have read and understood the Practice Guidelines. I wish to have access to my medical record online and understand and agree with the following statements:	
1. I will be responsible for the security of the information that I see or download	
2. If I share my information with anyone else it will be at my own risk	
3. I will contact the practice as soon as possible if I suspect that the account has been accessed by someone without my agreement	
4. 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 am the patient and I am the age of 16 or over	Sign and date here
PRINT NAME:	

If you are under the age of 16 and wish for a Parent/Guardian/Carer to have access to the above please ask the Receptionist for the appropriate online access form and consent forms.

For office use only	Staff member to complete below
Proof of ID given	Yes(please specify)
Identity Confirmed	Yes (please initial)
Staff member details	Print name and sign
Online registration documents printed (do NOT activate the DCR) and e-mail address verified in patient's system record.	Staff member print name, sign and date
Doctor has reviewed the medical record	GP sign here
DCR activated	Staff member print name, sign and date