**Patient Online: Registration form**

**Access to GP online services**

|  |  |  |  |
| --- | --- | --- | --- |
| Surname |  | | |
| First name |  | | |
| Date of birth |  | | |
| Address |  | | |
| Postcode |  | | |
| Email address |  | | |
| Telephone number |  | Mobile number |  |

## I wish to have access to the following online services (tick all that apply):

|  |  |
| --- | --- |
| 1. Booking appointments | 🞏 |
| 1. Requesting repeat prescriptions | 🞏 |
| 1. Accessing my medical record will display the following:  * Allergies * Medication * Adverse reactions | 🞏 |

# Application for online access to my medical record

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

|  |  |
| --- | --- |
| 1. I will be responsible for the security of the information that I see or download | 🞏 |
| 1. If I choose to share my information with anyone else, this is at my own risk | 🞏 |
| 1. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement | 🞏 |
| 1. 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 | 🞏 |

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

### For practice use only

|  |  |  |
| --- | --- | --- |
| Identity verified through  (tick all that apply) | Vouching 🞏  Vouching with information in record 🞏  Photo ID 🞏  Proof of residence 🞏 | Date |