Access to online services

(wef 01/04/16)

Application Form

Surname			
First name(s)			
Date of birth			
Address including postcode			
Email address			
Telephone number		Mobile number	

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

1. Booking appointments	☐
2. Requesting repeat prescriptions	☐
3. My detailed coded medical record *(including: problems and procedures, allergies, reactions, medication, test results and immunisations.*	☐

Application for online access to my medical record

I wish to access my medical record online and understand that consent to this is at the discretion of the GP Partners. I understand and agree with each statement below (please tick)

1. I have read and understood the information leaflet provided by the Practice.	☐
2. I will be responsible for the security of the information that I see or download.	☐
3. If I choose to share my information with anyone else, this is at my own risk.	☐
4. I will contact the Practice as soon as possible if I suspect that my account has been accessed by someone without my agreement.	☐
5. If I see information in my record that it not about me, or is inaccurate I will log out immediately and contact the Practice as soon as possible.	☐
6. I understand that an identity verification check will be made before I am given online access to my medical record and the repeat prescription service.	☐

Signature		Date	

For practice use only

Identity verified through (tick all that apply)	Vouching ☐ Vouching with information in record ☐ Photo ID ☐	Name of verifier	Date
Name of person who authorised (if applicable)			Date
Date account created			