



Access to GP online services Application Form

Surname			
First name(s)			
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	<input type="checkbox"/>
2. Requesting repeat prescriptions	<input type="checkbox"/>
3. Accessing elements of my medical record (<i>allergies, reactions, medication, test results and immunisations</i>)	<input type="checkbox"/>

Application for online access to my medical record

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

1. I have read and understood the information leaflet provided by the Practice.	<input type="checkbox"/>
2. I will be responsible for the security of the information that I see or download.	<input type="checkbox"/>
3. If I choose to share my information with anyone else, this is at my own risk.	<input type="checkbox"/>
4. I will contact the Practice as soon as possible if I suspect that my account has been accessed by someone without my agreement.	<input type="checkbox"/>
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.	<input type="checkbox"/>
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.	<input type="checkbox"/>

Signature	Date
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For practice use only

Identity verified through (tick all that apply)	Vouching <input type="checkbox"/> Vouching with information in record <input type="checkbox"/> Photo ID <input type="checkbox"/>	Name of verifier	Date
Name of person who authorised (if applicable)			Date
Date account created			