# Application for Online Services

|  |  |  |  |
| --- | --- | --- | --- |
| Surname | | Date of birth | |
| First name | | | |
| Address      Postcode | | | |
| Email address | | | Consent for communication by email? 🞏 |
| Telephone number | Mobile number | | Consent for communication by text message? 🞏 |

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

|  |  |
| --- | --- |
| 1. Booking appointments | 🞏 |
| 1. Requesting repeat prescriptions | 🞏 |
| 1. Limited access to parts of my medical record | 🞏 |

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

|  |  |
| --- | --- |
| 1. I have read and understood the information leaflet provided by the practice | 🞏 |
| 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 contact the practice as soon as possible | 🞏 |

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

### For practice use only

|  |  |  |  |
| --- | --- | --- | --- |
| Identity verified by  (initials) | Date | Method Vouching 🞏  Vouching with information in record 🞏  Photo ID and proof of residence 🞏  Specify……………………………………………………... | |
| Date account created | | | |
| Level of record access enabled  Contractual minimum √  Other……………………. ……… | | | Notes / explanation |