# 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 enabledContractual minimum √Other……………………. ………  | Notes / explanation |