PATIENT ACCESS APPLICATION FORM

PATIENT TO COMPLETE

NAME AND D.O.B	
ADDRESS	**CONTACT NUMBER & MOBILE NUMBER**
E-MAIL ADDRESS	
PRACTICE GUIDANCE READ AND UNDERSTOOD	**Delete as appropriate** **YES/NO**

FOR PRACTICE STAFF

Proof of ID Given e.g. passport, driving licence	**Yes/No**
Identity confirmed	**Yes/No** **Signed**

I have read and understood the Practice Guidance for the use of Patient Access. I understand that failure on my part to adhere to this guidance may result in my Patient Access registration being terminated. I also understand that this will not affect my registration within the practice. I acknowledge that the practice will send me reminders and requests for medical records updates.

SIGNED .....

Date .....