

Newland Medical Practice**Application for Online Access**

Surname	Date of birth
First name	
Address	
Postcode	
Preferred Email address (not shared):	
Telephone number	Preferred Mobile number

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

1. Booking / cancelling / viewing appointments (not available at the moment)	<input type="checkbox"/>
2. Requesting repeat prescriptions	<input type="checkbox"/>
3. Requesting acute prescriptions	<input type="checkbox"/>
4. Accessing my Online Summary (Medications & Allergies) (#93440) (not available at the moment)	<input type="checkbox"/>

I wish to use Online Services. Please read each statement carefully and tick before signing.

1. I have understood the information 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 is not about me or is inaccurate, I will contact the practice as soon as possible	<input type="checkbox"/>

I understand and agree with all the above statements:

Signature	Date
-----------	------

For practice use only

Patient CHI number		Vision ID number	
Identity verified by (initials)	Date	Method Vouching <input type="checkbox"/> Vouching with information in record <input type="checkbox"/> Photo ID and proof of residence <input type="checkbox"/>	
Authorised by (#91B)		Date	
Date account created			
Date registration letter/email sent			