Application form for online access to the practice online services

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| --- | --- | --- | --- | --- | --- | --- |
| Surname | Date of birth | | | | | |
| First name | | | | | | |
| Address  Postcode | | | | | | |
| Email address | | | | | | |
| Telephone number | | | Mobile number | | | |
| I wish to have access to the following online services (please tick all that apply): | | | | | | |
| 1. Booking appointments | | | | | | □ |
| 2. Requesting repeat prescriptions | | | | | | □ |
| 3. Accessing 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 | | | | | | □ |
| 2. I will be responsible for the security of the information that I see or download | | | | | | □ |
| 3. If I choose to share my information with anyone else, this is at my own risk | | | | | | □ |
| 4. If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible | | | | | | □ |
| 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 | | | | | | □ |
| 6. If I think that I may come under pressure to give access to someone else unwillingly I will contact the practice as soon as possible. | | | | | | □ |
| Signature | | | | Date | |  |
| For practice use only | | | | | |  |
| Patient NHS number | | | | Practice computer ID number | | |
| Identity verified by (initials)  Date | | Method used | | Vouching □  Vouching with information in record □ Photo ID and proof of residence □ | | |
| Documentary evidence provided | | | | |  | |
| Authorised by | | | | | Date | |
| Date account created | | | | | | |
| Date login credentials emailed/given | | | | | | |
| Level of record access enabled  Detailed coded record □  All prospective □  All retrospective (from 1st November 2023 only) □  Other limited parts □ | | | | Notes / explanation | | |
| Date clinical assurance completed | | | | Assured by (initials) | | |
| Reason for refusal if record access is refused after clinical assurance. | | | | | | |