

PATIENT ONLINE: REGISTRATION FORM: ACCESS to GP online services

Please complete this form and hand it to the practice, please also provide your proof of identity and proof of address. Once we have received your form and seen the necessary proof of identity, your request will have to be processed by the admin team and you will be provided with a registration letter which you can use to register for your on-line account. Please note that each individual family member would need to complete this application form as each individual needs to have their own account.

Name:	
D.O.B:	
Address:	
Tel No:	
Mob No:	
Email address: <i>Please print clearly</i>	

By providing your mobile number you are consenting to receiving FREE text reminders of your appointments, and to letting us know if your number changes, if you DO NOT want to receive a FREE text appointment reminder please tick this box:

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

1. Booking appointments	<input type="checkbox"/>
2. Requesting repeat prescriptions	<input type="checkbox"/>
3. Access to my Core Summary Record (medications and allergies)	<input type="checkbox"/>
<i>*Please ask for a further application form if you wish to request access to your full medical record (SAR request)*</i>	

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

Patients Signature:	
Date:	

For practice use only

Identity verified through (tick all that apply)	Vouching <input type="checkbox"/> Vouching with information in record <input type="checkbox"/> Photo ID <input type="checkbox"/> Proof of residence <input type="checkbox"/>	Name of verifier	Date
Name of person who authorised (if applicable)			Date
Date account created			
Date passphrase sent			

Please note that we only provide online access to patients over the age of 16