Application form for online access to the practice online services

|  |  |
| --- | --- |
| Surname | Date of birth |
| First name |
| AddressPostcode |
| Email address |
| Telephone number | Mobile number |
| I wish to have access to the following online services for myself [ ]  / for my child (Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ) under 13 years of age [ ]  (please tick all that apply): |
| 1. Booking appointments | [ ]  |
| 2. Requesting repeat prescriptions | [ ]  |
| 3. Accessing my / my child’s medical record | [ ]  |
| I wish to access my [ ] /my child’s [ ]  medical record online and understand and agree with each  statement (Please 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 enabledDetailed coded record [ ]  Other limited parts [ ]   | Notes / explanation |
| Date clinical assurance completed | Assured by (initials) |
| Reason for refusal if record access is refused after clinical assurance. |