**Application for Patient Online Services (only available to over 16’s) Please supply photo identification and proof of address when bringing the form back.**

|  |  |
| --- | --- |
| Surname | Date of birth |
| First name |
| AddressPostcode |
| Email address |
| Telephone number | Mobile number |

I wish to have access to the following online services:

|  |  |
| --- | --- |
| 1. Book Appointments (on the day and prebookable)
 |  |
| 1. Request Repeat Medications
 |  |
| 1. View Summary Care Record (medications, allergies, bad reactions)
 |  |
| 1. View Immunisations and Test Results
 |  |
| 1. View Documents
 |  |
| 1. View ‘Problems’
 |  |

I wish to access services online and understand and agree with each statement (tick)

|  |  |
| --- | --- |
| 1. I agree to my access code to be emailed to above email address |  |
| 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. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement |  |
| 5. If I see information in my record that is not about me or is incorrect, 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 | MethodVouching Vouching with information in record Photo ID and proof of residence  |
| Date account created |  |