

**ONLINE PATIENT ACCESS REGISTRATION**

Surname		Forename	
Address			
Postcode		Date of Birth	
Email		Mobile	

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

1. Booking appointments	<input type="checkbox"/>
2. Requesting repeat prescriptions	<input type="checkbox"/>
3. Accessing my medical record	<input type="checkbox"/>

**I wish to access my medical record online and understand and agree with each statement (tick)**

1. I have read and understood the information provided on the Practice website	<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. If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible	<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"/>
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.	<input type="checkbox"/>

Signed:	
Date:	

**For practice use only**

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	Date:		
Date account created			
Date passphrase sent			

