Patient Online registration form - Access to GP online services

Name			
Date of birth			
Address			
Email address			
Telephone number		Mobile number	

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

1. Booking appointments	☐
2. Requesting repeat prescriptions	☐
3. Accessing my medical record	☐
4. Pathology Results	☐

Application for online access to my medical record

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

1. I have read and understood the information on the reverse of this form	☐
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 it not about me, or is inaccurate I will log out immediately and contact the practice as soon as possible	☐
6. I have understood and will adhere to the practice policy for the use of on-line booking. I will ensure the safe keeping of my user name and password. I understand that failure on my part to adhere to the policy may result in my on-line booking registration being terminated. I understand that this will in no way affect my registration with the practice.	☐

Signature		Date	

For practice use only

Identity verified through (tick all that apply)	Vouching ☐ Vouching with information in record ☐ Photo ID ☐ Proof of residence ☐	Name of verifier	Date
Name of person who authorised (if applicable)			Date