

Application form for online access to the practice online services

This form should only be used to sign up for online access for yourself. You will need to complete a proxy access form to gain access for your children or another person. Please **ONLY** use this form if you are aged 11 and over. Your account must have a unique email address (you cannot set up more than one patient using the same email). For children under 11 years please apply using our proxy access form after you have set up your own online access.

Surname		Date of birth	
First name			
Address			
Postcode			
Email address			
Telephone number		Mobile number	
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 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. 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"/>	
Signature			Date
For practice use only			
Patient NHS number		Practice computer ID number	
Identity verified by (initials)		Method used	
		Vouching <input type="checkbox"/> Vouching with information in record <input type="checkbox"/> Photo ID and proof of residence <input type="checkbox"/>	
Documentary evidence provided			Date
Authorised by			Date
Date account created			
Date login credentials emailed/given			
Level of record access enabled		Notes / explanation	
Detailed coded record <input type="checkbox"/> All prospective <input type="checkbox"/> All retrospective <input type="checkbox"/> Other limited parts <input type="checkbox"/> <input type="checkbox"/>			
Date clinical assurance completed		Assured by (initials)	
Reason for refusal if record access is refused after clinical assurance.			