**Access to GP online services**

|  |  |
| --- | --- |
| Surname |  |
| First Name |  |
| Date of Birth |  |
| Address |  |
| Postcode |  |
| Email address |  |
| Landline number  Mobile number |  |

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

|  |  |
| --- | --- |
| Booking appointments |  |
| Requesting repeat prescriptions |  |
| Accessing my medical record |  |

**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**)

|  |  |
| --- | --- |
| I have read & understood the information leaflet provided by the practice |  |
| I will be responsible for the security of the information that I see or download |  |
| If I choose to share my information with anyone else, this is at my own risk |  |
| I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement |  |
| If I see information in my record that is not about me, or is inaccurate I will log out immediately and contact the practice as soon as possible |  |

Signature ………………………………………………………………………….

Date………………………………………………………………………………….

**Please provide the following documents for proof of ID**

Photo ID (Passport or Driving License)

Proof of Address (Utility bill, Bank statement or letter from benefit agency)

**FOR ADMIN USE ONLY**

Identity verified by staff member………………………………………………….. Staff member Signature………………………………………………..

Photo ID & proof of residence……………………………………………………….. Vouching………………………………………………………………………

Date………………………………………………………………. Access letter given to patient……………………………………….

|  |
| --- |
| Read coded as ID verified by Staff Member (912P)…………………………………………  Name……………………………………………………………........... Signature……………………………………………………………… |