**Registration Form For Access to Patient Access**

|  |  |
| --- | --- |
| Surname: |  |
| First name: |  |
| Date of birth |  |
| Address |  |
| Postcode |  |
| Email address  |  |
| Contact number |  |  |  |
| *If applying for access to a child’s medical record please complete below:*I confirm that I have parental responsibility for the child named above………………… 🞏 |

## Due to GDPR and data protection requirements all users will need an individual email address to sign up for online access.

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

|  |  |
| --- | --- |
| 1. Booking appointments
 | 🞏 |
| 1. Requesting repeat prescriptions
 | 🞏 |
| 1. Accessing my medical record (Test results & immunisations)
 | 🞏 |

I wish to access my/or my child’s medical record online and understand and agree with each statement (please tick)

|  |  |
| --- | --- |
| 1. I will be responsible for the security of the information that I see or download | 🞏 |
| 2. If I choose to share my information with anyone else, this is at my own risk | 🞏 |
| 3. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement | 🞏 |
| 4. 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 | 🞏 |

|  |  |  |  |
| --- | --- | --- | --- |
| Signature |  | Date |  |

### When completed please take this to reception along with photo ID and proof of residence.

### Once your application has been processed you will be sent your account information.

### For practice use

|  |  |  |  |
| --- | --- | --- | --- |
| Identity verified through(tick all that apply)(If not vouching both photo ID & proof of residence required) | Photo ID 🞏Proof of residence 🞏 | Name of verifier | Date |