



## APPLICATION TO ACCESS GP ONLINE SERVICES

**\*\*PLEASE ENSURE YOU PROVIDE PROOF OF IDENTITY\*\***

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"/>

Preferred method of communication (please tick one option):

1. Email	<input type="checkbox"/>
2. Letter	<input type="checkbox"/>
3. SMS	<input type="checkbox"/>

Signature:	Date:
------------	-------



**For practice use only**

Patient NHS number		Practice computer ID number	
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			