|  |
| --- |
| Surname: Date of Birth:  |
| First Names:  |
| Address: Post Code:  |
|  Email Address:  |
|  Telephone: Mobile:  |

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

|  |
| --- |
| 1. Requesting repeat prescriptions |[ ]
| 2. Accessing my medical record |[ ]

I wish to access my medical record online and understand and agree with each statement (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. If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible |[ ]
| 4. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible |[ ]
| 5. 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.  |[ ]

 Signature: Date:

# For practice use only

|  |  |  |
| --- | --- | --- |
| Identity verified by (initials) | Date | MethodVouching Vouching with information in record Photo ID and proof of residence  |
| Authorised by | Date |
| Date account created |

Created 19.05.2021