ACCESS TO GP ONLINE SERVICES
REGISTRATION FORM

Surname:	
Forename:	
Date of birth:	
Address:	
Postcode:	
Email address:	
Telephone –home:	
Telephone – mobile:	

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*)

I have read and understand the information leaflet provided by the practice.	
I will be responsible for the information 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 on my account that is not about me, or is inaccurate I will contact the practice as soon as possible.	

Signature:		**Date:**	

You will need to make an appointment with our on-line team to verify your ID to enable your application for on-line access to be processed.

For practice use ONLY

<table>
<tr><td>Identity verified through (tick all that apply)</td><td colspan="2">☐ Vouching
☐ Vouching with information in the record
☐ Photo ID
☐ Proof of residence</td><td>Verified by:</td><td>Date:</td></tr>
<tr><td>Name of person who authorized (if applicable)</td><td colspan="3"></td><td>Date:</td></tr>
<tr><td>NHS number:</td><td></td><td colspan="2">Practice computer ID number:</td><td></td></tr>
<tr><td>Date account created.</td><td colspan="4"></td></tr>
<tr><td>Date passphrase sent:</td><td colspan="4"></td></tr>
<tr><td>Level of record access enabled:</td><td colspan="4">☐ Prospective
☐ Retrospective
☐ All
☐ Limited parts
☐ Contractual minimum</td></tr>
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