Patient Online Registration Application Form

Access to Online Services – For patients aged 18 or over only

Before you complete this form, please read the “**Access to Online Services Patient Information’** leaflet provided to you by Reception, which explains the levels of information available and how to make an informed choice regarding online access to your record.

Please complete this form and return it to the practice, along with two forms of identification one of which must be photographic.

|  |  |
| --- | --- |
| Surname: | Date of Birth: |
| First Name: | Gender: |
| Address:  Postcode: | |
| Email Address: | |
| Home Number: | Mobile Number: |

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

|  |  |
| --- | --- |
| Standard Access **Tick ✓** | |
| 1. Booking appointments |  |
| 1. Requesting repeat prescriptions |  |
| 1. Accessing my Core Summary Medical Record– Medication, Allergies & Adverse Reactions and Immunisation history |  |
| Enhanced Access (in addition to standard access) **Tick ✓** | |
| 1. Accessing my detailed coded record– Results, Problems, Diagnoses and Procedures. |  |
| 1. Accessing my Clinical Documents and free text information |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| I understand and agree with each statement below: **Tick ✓** | | | | |
| I wish to access my medical record online and I agree that I have read and understood the information leaflet | | | |  |
| I will be responsible for keeping any information I read, copy, download or print, safe and secure | | | |  |
| I agree that if I choose to share my information with anyone else, this is at my own risk | | | |  |
| If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible | | | |  |
| I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement or if I think I may come under pressure to give access to someone else unwillingly. | | | |  |
| How would you like to receive your online access pin? (please tick) | Email □ | Post □ | SMS □ | | |

|  |  |
| --- | --- |
| Patient Signature: | Date: |

**For Practice use only**

|  |  |  |
| --- | --- | --- |
| Patient NHS number: | | Practice computer ID number: |
| Identity verified by (initials) | Date | Method  □ Vouching  □ Vouching with information in record  □Photo ID and proof of residence |
| Authorised by: | | Date: |
| Date account created: | | |
| Date login details provided: | | |
| Level of record access enabled  Standard Access □  Enhanced Access □ | | Notes/ explanation |