## Application form for online access to the practice online services

| Surname | Date of birth |
|---|---|
| First name | |
| Address<br><br><br>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 | ☐ |
| 2. Requesting repeat prescriptions | ☐ |
| 3. Accessing immunisations records, lab results, allergies | ☐ |

I 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**

| | | |
|---|---|---|
| Patient NHS number | Practice computer ID number | |
| Identity verified by (initials) and date | Method used | Vouching ☐<br>Vouching with information in record ☐ |
| Documentary evidence provided | | |
| Authorised by | Date | |
| Date account created | | |
| Date login credentials emailed/given | | |
| Date clinical assurance completed | Assured by (initials) | |