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| **CHURCH STREET PRACTICE** |

**Patient Online: Registration Form for those aged 16 and over**

|  |  |
| --- | --- |
| Surname |  |
| First name |  |
| Date of birth |  |
| Address |  |
| Email address |  |
| Telephone No. |  | Mobile No. |  |

## Access to GP online services

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

|  |  |
| --- | --- |
| 1. Booking appointments
 | 🞏 |
| 1. Requesting repeat prescriptions
 | 🞏 |
| 1. Accessing my medical record
 | 🞏 |
| 1. Sign up for SMS messaging and appointment reminders (mobile no. must be provided above
 | 🞏 |

# 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)

|  |  |
| --- | --- |
| 1. I have read and understood the information leaflet provided by the practice
 | 🞏 |
| 1. I will be responsible for the security of the information that I see or download
 | 🞏 |
| 1. If I choose to share my information with anyone else, this is at my own risk
 | 🞏 |
| 1. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement
 | 🞏 |
| 1. If I see information in my record that it not about me, or is inaccurate I will log out immediately and contact the practice as soon as possible
 | 🞏 |

|  |  |  |  |
| --- | --- | --- | --- |
| Signature |  | Date |  |

### Please bring Photo ID with you when you return this form to the Practice.

### For practice use only

|  |  |
| --- | --- |
| Identity verified through(tick all that apply) | Vouching 🞏 Vouching with information in record 🞏Photo ID 🞏 Proof of residence 🞏 |
| Name of Verifier |  | Date |  |
| Name of Authoriser |  | Date |  |
| Date account created  |  | Date passphrase sent |  |