Swallowfield Medical Practice

Patient Online registration form - Access to GP online services

Surname		Date of Birth:
First name		
Address	Postcode:	Telephone: Mobile:
Email address		

I wish to have access to the following **online services** (please tick):

1. Booking appointments	☐
2. Requesting repeat prescriptions	☐

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	☐
2. I will be responsible for the security of the information that I see or download	☐
3. If I choose to share my information with anyone else, this is at my own risk	☐
4. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	☐
5. 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:

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: Verification Date:
Read code 91B date:	Read code 91B entered by:	Date account created:
Date passphrase sent:	GP authorising access to medical record:	Authorisation Date:
Read code 93440 date:	Read code 93440 entered by:	