Application for Online Services

PLEASE PRINT AND COMPLETE THE FOLLOWING BEFORE RETURNING IT TO THE PRACTICE ALONG WITH YOUR PHOTOGRAPHIC ID

First name(s): _____ Surname: _____

Date of birth: _____

Address: _____

_____ Postcode: _____

Email: _____ Telephone: _____

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

- ☐ Booking appointments
- ☐ Requesting repeat prescriptions
- ☐ Medical record

I agree with the following statements:

- ☐ I have read and understood the information leaflet provided by the practice
- ☐ I am responsible for the security of the information I see or download
- ☐ If I choose to share my information with anyone else, I do so at my own risk
- ☐ If I see information in my record that is not about me or is inaccurate, I will contact the surgery as soon as possible.

Your request for online services will be processed as soon as possible.
If accepted, you can expect to have access within 21 days from application and will be notified by email.

Signed: _____

Date: _____

FOR PRACTICE USE ONLY

Patient name: _____ **Notes:**

NHS number: _____

Date of application: _____

ID given:

- ☐ **Passport**
- ☐ **Driving Licence**
- ☐ **Other**

Verified by: _____

Signed: _____

Date: _____

- ☐ **Access granted**
- ☐ **Access denied**