**Patient Online: Registration Form**

**Access to GP Online Services**

|  |  |
| --- | --- |
| Surname |  |
| First Name  |  |
| Date of birth  |  |
| Address |  |
| Postcode |  |
| Email address |  | □ |
| Telephone number |  | □ |
| Mobile number |  | □ |

***Please tick the box to indicate your preferred method of contact***

If you wish to consent to the SMS texting service, please sign the declaration below:

**I CONSENT to the practice contacting me by text message for the purpose of health information, appointment reminders and test results.**

I acknowledge that it is my responsibility to inform The White House Surgery of any change in my mobile number or if the number is no longer in my possession and also advise the surgery if my email address changes.

Sign ……………………………………….. Date ……………………………

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

|  |  |
| --- | --- |
| 1. Booking appointments
 | □ |
| 1. Requesting repeat prescriptions
 | □ |
| 1. Summary record access **(medication, allergies and immunisations)**
 | □ |
| 1. Detail coded record access **(please note if you are applying for detail coded record access it may take up to 6 months for us to process your request)**
 | □ |

|  |  |  |  |
| --- | --- | --- | --- |
| How would you like to receive your online access pin? (please tick) | Email □ | Post □ | SMS □ |

**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. If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible |  |
| 5. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible |   |
| 6. 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**

|  |  |  |
| --- | --- | --- |
|  Identity verified by  | Date | Method Vouching Photo ID  |
|  Authorised by | Date |
|  Date account created |
|  Date passphrase sent |