APPLICATION FOR PATIENT ONLINE SERVICES – SAVILLE MEDICAL GROUP (Annex A)

Surname		Forename(s)	
Street		Area	
Town or city		Postcode	
Phone number		Mobile	
Email			
I wish to have access to the following information (tick which apply):			
Booking appointments			
Requesting repeat prescriptions			
Accessing my medical record			

I wish to access my health record online and understand and agree with the following statements:

I have read and understood the information leaflet provided by the practice.	
I will be responsible for the security of the information that I see or download.	
If I choose to share my information with anyone else, this is at my own risk.	
If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible.	
If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible.	
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)	Date	Method Vouching ☐ Vouching with information in record ☐ Photo ID and proof of residence ☐	
Authorising GP		Date	
Date account created			
Date passphrase sent			
Level of record access enabled All ☐ Prospective ☐ Retrospective ☐ Detailed coded record ☐ Limited parts ☐		Notes / explanation	