**ONLINE SERVICES - PATIENT APPLICATION FORM**

**Please present this to reception with your ID. Thank you.**

**If you are requesting access for yourself**, please only complete ‘My Details’.

**If you are requesting access to someone else’s online services,** such as a child or someone else you assist/care for, *either* you will need to provide evidence this access is appropriate (such as proof you are the parent e.g. Birth certificate) *or* we will need to have the patient themselves confirm they consent to your access.

|  |  |  |
| --- | --- | --- |
|  | **My Details**  | **Person(s) you are requesting online service access to** |
| **Person 1** | **Person 2** |
| **Surname:** |  |  |  |
| **Forename(s):** |  |  |  |
| **Date of Birth:** |  |  |  |
| **Address:** |  | (If different to your own) | (If different to your own) |
| **Tel. No:** |  | **Your relation to Person 1**e.g. Parent/Carer/Partner etc | **Your relation to Person 2**e.g. Parent/Carer/Partner etc |
| **Mobile No:** |  |  |  |
| *By providing your mobile number you are consenting to receiving FREE text reminders of your appointments and to letting us know if your number changes, if you* ***DO NOT*** *want to receive a FREE text appointment reminder please tick this box:* □ |
| **Email Address: Please print clearly** **pL** |  |
| **I am requesting access to… (please tick as appropriate)** |
| **Book/cancel appointments** | [ ]  | [ ]  | [ ]  |
| **Request prescriptions** | [ ]  | [ ]  | [ ]  |
| **Record access** | [ ]  | [ ]  | [ ]  |

**Access to online services for children:** Please note you will automatically lose access to a child’s online services as they get older[[1]](#footnote-1). Access after this will be based on the child’s own decision (if deemed competent to make these decisions) or can be re-added for short periods pending another assessment of the child’s capacity/decisions.

|  |  |
| --- | --- |
| 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. If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible
 |  |
| 1. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible.
 |  |
| 1. 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.
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|  |  |
| --- | --- |
| **Patients Signature:** |  |
| **Date:** |  |

**For completion by Practice Staff 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 person who authorised (if applicable)** |  | **Date** |
| **Date account created** | **……./……./20……..** |
| **Date user login details supplied?** | **Date: ……./……./20………. Method: By hand / Post / SMS / Email** |

1. Aged is based on the current practice policy. [↑](#footnote-ref-1)