# Application for online access

***Identification is required to process this application. Please bring photo ID to Reception with this form to obtain your online access***

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

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

|  |  |
| --- | --- |
| 1. Booking appointments
 | 🞏 |
| 1. Requesting repeat prescriptions
 | 🞏 |
| 1. Completing online questionnaires
 | 🞏 |
| 1. Accessing my medical record *(only available for patients over 18yrs)*
 | 🞏 |

I wish to access Arden Medical Centre’s online services and understand and agree with each statement (tick)

|  |  |
| --- | --- |
| 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. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement
 | 🞏 |
| 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
 | 🞏 |

|  |  |
| --- | --- |
| Signature | Date |

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### For practice use only

|  |  |
| --- | --- |
| Patient NHS number |  |
| Identity verified by(initials) | Date | Method Photo ID 🞏Vouching 🞏Vouching with information in record 🞏  |
| Date account created & passphrase given |
| Level of record access enabledBooking appointments 🞏Repeat prescriptions 🞏Complete Questionnaires 🞏Summary Care Record 🞏 | Notes / explanation |

*Please put completed form for scanning (non-workflow)*