**BEECHWOOD SURGERY**

**Patient online registration form**

**Access to GP online services**

|  |  |
| --- | --- |
| 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):

|  |  |
| --- | --- |
| Booking appointments | 🞏 |
| Requesting repeat prescriptions | 🞏 |
| Limited access to parts of my medical record  | 🞏 |

I wish to access my medical record online and understand and agree with each statement (tick)

|  |  |
| --- | --- |
| 1. I have read and understood the information leaflet provided by the Surgery
 | 🞏 |
| 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 | 🞏 |
| I will contact the surgery as soon as possible if I suspect that my account has been accessed by someone without my agreement | 🞏 |
| If I see information in my record that is not about me or is inaccurate, I will contact the surgery as soon as possible | 🞏 |

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

**For surgery use only**

|  |  |
| --- | --- |
| Patient NHS number | Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Identity verified by(Staff Name) | Date | **Method**Photo ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Proof of Address: (within 3 months)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Authorised by  | Date |
| Date account created  |
| Date passphrase sent/given |
| Level of record access enabledContractual minimum √Other……………………. ………  | Notes / explanation |