# Application for Online Access

|  |  |
| --- | --- |
| Surname | Date of birth |
| First name |
| Address   Postcode  |
| Preferred Email address (not shared):  |
| Telephone number | Preferred Mobile number |

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

|  |  |
| --- | --- |
| 1. Cancelling / viewing appointments
 | 🞏 |
| 1. Requesting repeat prescriptions
 | 🞏 |
| 1. Requesting acute prescriptions
 | 🞏 |

**I wish to use Online Services. Please read each statement carefully and tick before signing.**

|  |  |
| --- | --- |
| 1. I have understood the information 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
 | 🞏 |

**I understand and agree with all the above statements:**

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

### For practice use only

|  |  |
| --- | --- |
| Patient CHI number | Vision ID number |
| Identity verified by(initials) | Date | MethodVouching 🞏Vouching with information in record **X** **Photo ID and proof of residence 🞏** |
| Authorised by  **(#91B)** | Date |
| Date account created |
| Date registration letter/email sent  |