**The Acocks Green Medical Centre**

**Patient Online: Registration Form**

**Access to GP online services**

|  |  |
| --- | --- |
| Surname: |  |
| First name: |  |
| Date of birth: |  |
| Address: |  |
|  |  |
|  |  |
| Postcode: |  |
| Email address: |  |
| Tele. Number: |  |
| Mobile number: |  |

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

|  |  |
| --- | --- |
| 1. Booking appointments
 | 🞏 |
| 1. Requesting repeat prescriptions
 | 🞏 |
| 1. Accessing my medical record
 | 🞏 |

**I wish to access my medical record online and understand and agree with each statement (please 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 it not about me, or is inaccurate I will contact the practice as soon as possible
 | 🞏 |

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

### For practice use 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 |
| NHS Number |  |