

## Claremont and Holyport Surgeries Online Services Application Form

*By completing this form, I confirm I would like access to online services. By signing this form, I adhere to use the system responsibly in accordance with all instructions given to me by my GP Practice. I agree to inform my GP Practice of any errors I see within my record whilst I use the system.*

<b>Surname:</b>	<b>First Name:</b>
<b>Date of Birth:</b>	<b>NHS Number:</b>
<b>Address:</b>	
<b>Postcode:</b>	
<b>Email:</b>	<b>By giving your email address you are consenting to be contacted by email</b>
<b>Home Telephone:</b>	<b>Mobile:</b>

**Is this application for you?**

Yes

No (If no please state below who it is for and the relationship)

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**Please note: If you are requesting proxy access to online services, we will need written consent from the person regarding access to their medical records.**

By completing this form, you are asking for access to the following –

- Repeat Prescriptions
- Test Results
- Medical History e.g. Allergies, Immunisations, Problems, consultations, documents

I agree to be responsible for the security of the information that I see or download. I understand that if I choose to share my information with anyone else, this is at my own risk. I understand that I should contact the practice as soon as possible if I suspect my account has been accessed without my permission or unlawfully. I understand I will contact the practice should I see any information that is incorrect.

**Signed:** \_\_\_\_\_ **Name (Printed):** \_\_\_\_\_

Practice Use only:

Identity verified by:

ID Seen: Passport / Driving Licence / Other Photo ID \_\_\_\_\_

Authorised by:

Date: