



# Patient Online Registration Form

	Applicant	Also fill in below if applying for a child under 14 or for proxy access
Name		
Date of birth		
Address		
Tel. Mobile & landline		

**Registration details will be sent to you by text - N.B. If you do not have a mobile number or you have dissented from texting, please collect your form from reception in two weeks.**

I wish to have access to the online services, this currently includes booking appointments, requesting repeat prescriptions, and accessing medical records ( <i>more functionalities will be available in the future</i> )	<input type="checkbox"/>
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### What rights of access do you have to the patient notes?

1. I am the patient	<input type="checkbox"/>
2. I am the parent/guardian of the child under 14	<input type="checkbox"/>
3. I have patient consent for me to act as proxy on their behalf – please state reason..... Patient Signature ..... Date .....	<input type="checkbox"/>
4. Patient incapacity – please provide us with specific legal proof.e.g. Power of attorney Verified by ..... Date .....	<input type="checkbox"/>

### I understand and agree with each statement (please tick)

1. I have read and understood the information leaflet provided by the practice	<input type="checkbox"/>
2. I will be responsible for the security of the information that I see or download	<input type="checkbox"/>
3. If I choose to share the information with anyone else, this is at my own risk	<input type="checkbox"/>
4. I will contact the practice as soon as possible if I suspect that the account has been accessed by someone without my agreement	<input type="checkbox"/>
5. If I see information in my record that is not about the patient, or is inaccurate I will log out immediately and contact the surgery as soon as possible	<input type="checkbox"/>
6. I understand that for the registrations of children under 14 access will be closed when the child reaches 14 years of age and the child will need to register again separately	<input type="checkbox"/>
7. If I think that I may come under pressure to give access to someone else unwillingly, I will contact the practice as soon as possible.	<input type="checkbox"/>

### Signature of person applying for online access

..... Date .....

Driving Licence <input type="checkbox"/> Birth Certificate <input type="checkbox"/> Passport <input type="checkbox"/> Personally vouched for <input type="checkbox"/> Other .....	Name of Verifier	Date
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**NB: PTO WHEN STAFF DOING REGISTRATION**

ALL proxy access requests and online requests for under 16s MUST be appropriately considered – e.g. check ID of parent/carer.

Staffing authorising to sign and date

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Admin processing –

Check overleaf what access is to be ticked

***UNDER NO CIRCUMSTANCES TICK ACCESS TO MEDICAL RECORD***

SMS sent with passwords and username .....

Or – all actioned and printed.....

Other .....

Staff signature & date .....

PLEASE SCAN ON TO PATIENT NOTES