**Newbury Group Practice**

**Online Access Registration Form (16years and above)**

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| --- | --- |
| Surname: | Date of Birth: |
| First Name: | |
| Address:  Postcode: | |
| Email: | |
| Tel: | Mob: |

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

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

**Please be aware that patients requesting to access their partial medical summary will need to provide photo ID (Passport or Driving License) when submitting their application.**

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 for download | ☐ |
| 1. If I chose 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 | ☐ |
| 1. I understand that it may take a few weeks to obtain access to my medical record online. This includes current medication and allergies | ☐ |

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

For practice use only:

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| --- | --- | --- |
| Patient NHS Number: | Practice EMIS ID Number: | |
| Identify verified by (Initials): | Date: | Method: Vouching ☐  Vouching with information in record ☐  Photo ID & Proof of residence ☐ |
| Date Account Created: | | |