GRAHAM ROAD SURGERY

NHS England

Patient Registration Form - Access to GP Online Services

Surname	
First Name	
Date of Birth:	
Address:	
Postcode	
A UNIQUE EMAIL ADDRESS IS REQUIRED FOR REGISTRATION	
Email Address	
Telephone No.	
Mobile No.	

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

1. Booking appointments	
2. Requesting repeat prescriptions	
3. Accessing my medical record	
Do you already have access can login successfully? Please answer Yes or No	

Application for online access to 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 online provided by the practice	
2. I will be responsible for the security of the information that I see or download	
3. If I choose to share my information with anyone else, this is at my own risk	
4. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	
5. If I see information in my record that is not about me, or is inaccurate, I will log out immediately and contact the practice as soon as possible	

Signature:____**Date:**__________

For practice use only:

Identity verified through: Vouching ☐ Vouching with information in record ☐ Photo ID☐	Name of Verifier (Team Member): Date:
Name of person who authorised	
Date account created	
Date letter sent	