



The Brooke Surgery	
--------------------	--

Patient Online: Registration form Access to GP online services

Surname			
First name			
Date of birth			
Address			
Postcode			
Email address			
Telephone number		Mobile number	

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

1. Booking appointments	<input type="checkbox"/>
2. Requesting repeat prescriptions	<input type="checkbox"/>
3. Accessing my medical record	<input type="checkbox"/>

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 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 my 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 my account has been accessed by someone without my agreement	<input type="checkbox"/>
5. If I see information in my record that it not about me, or is inaccurate I will log out immediately and contact the practice as soon as possible	<input type="checkbox"/>

Signature		Date	
-----------	--	------	--

For practice use only

Identity verified through (tick all that apply)	Vouching <input type="checkbox"/>	Name of verifier	Date
	Vouching with information in record <input type="checkbox"/>		
	Photo ID <input type="checkbox"/>		
	Proof of residence <input type="checkbox"/>		
Name of person who authorised (if applicable)			Date
Date account created			
Date PIN sent			