*Park Lane Surgery*

**ONLINE SERVICES PATIENT REGISTRATION FORM**

**PLEASE COMPLETE FORM IN BLOCK CAPITALS USING BLACK INK**

|  |  |
| --- | --- |
| **Surname:** |  |
| **First name:** |  |
| **Date of birth:** |  |
| **Address:** |  |
| **Postcode:** |  |
| **Email address:** |  |
| **Telephone number:** |  | **Mobile number:** |  |

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

|  |  |
| --- | --- |
| Online appointments booking | Already Granted |
| Online prescription management | Already Granted |
| Accessing my medical record  | [ ]  |

I understand my responsibility for safeguarding sensitive medical information and I understand and agree with each of the following statements:

|  |  |
| --- | --- |
| I have read and understood the information leaflet provided by the practice | [ ]  |
| I will be responsible for the security of the information that I/we see or download | [ ]  |
| If I choose to share my information with anyone else, this is at my own risk | [ ]  |
| I will contact the practice as soon as possible if I suspect that the account has been accessed by someone without my agreement | [ ]  |
| If I see information in the record that is not about me, or is inaccurate, I will contact the practice as soon as possible | [ ]  |

|  |  |  |  |
| --- | --- | --- | --- |
| Signature of patient: |  | Date: |  |

**For practice use only**

|  |  |
| --- | --- |
| Patient NHS No. |  |
| Identity verified by(initials) | Date | Method of verification |  |
| Vouching | [ ]  |
| Vouching with information in record  | [ ]  |
| Photo ID and proof of residence | [ ]  |
| Authorised by: |  | Date: |  |
| Date account created: |  |
| Date log in details sent/given:  |  |
| Level of record access enabled  | Notes / Explanation |
| All | [ ]  |
| Prospective | [ ]  |
| Retrospective  | [ ]  |
| Limited parts | [ ]  |
| Contractual minimum | [ ]  |