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| **Chipping Norton Health Centre** |

**Patient Online: Registration Form**

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| --- | --- |
| Surname |  |
| First name |  |
| Date of birth |  |
| Address |  |
| Email address **(You must use a different email address to your partner or any other family member)** |  |
| Telephone no. | Mobile no. |

## Access to GP online services

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

|  |  |
| --- | --- |
| 1. Booking appointments (**Only available for routine blood appointments**) | 🞏 |
| 1. Requesting repeat prescriptions | 🞏 |
| 1. Accessing my medical record | 🞏 |

# 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 | 🞏 |
| 1. I will be responsible for the security of the information that I see or download | 🞏 |
| 1. If I choose 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 it 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**  **(tick all that apply)** | **Vouching 🞏 Vouching with information in record 🞏**  **Photo ID 🞏 Proof of residence 🞏** | | | |
| **Name of Verifier / Authoriser** |  | | **Date** |  |
| **Date account created** |  | **Date registration letter**  **sent / emailed** | |  |
| **Passed for scanning** | **🞏** | **GP agreed access to detailed record** | | **Y N** |
| **Notes / data summarised** |  | | | |