# Application for Online Access

|  |  |
| --- | --- |
| Surname | Date of birth |
| First name | |
| Address      Postcode | |
| Preferred Email address (not shared): | |
| Telephone number | Preferred Mobile number |

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

|  |  |
| --- | --- |
| 1. Booking appointments **(currently Unavailable)** | 🞏 |
| 1. Requesting repeat prescriptions | 🞏 |
| 1. Requesting acute prescriptions (not on repeat list) | 🞏 |

**I wish to use Online Services. Please read each statement carefully and tick before signing.**

|  |  |
| --- | --- |
| 1. 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 is not about me or is inaccurate, I will contact the practice as soon as possible | 🞏 |

The Practice complies with Data Protection and Access to Medical Records legislation. A copy of our Privacy Notice can be found at this link:- [Hamilton Medical Group - Privacy Notice for Patients](https://hamiltonmedicalgroup.co.uk/website/N30218/files/HMG%20Privacy%20Notice%20for%20Patients%20(updated%2001.02.2021).pdf)

**I understand and agree with all the above statements:**

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

### For practice use only

|  |  |  |  |
| --- | --- | --- | --- |
| Identity verified by  (initials) | Date | Method  Vouching 🞏  Vouching with information in record 🞏 | |
| Authorised by  **(#91B)** | | | Date |
| Date account created | | | |
| Date registration letter/token sent | | | |
| Level of record access enabled Contractual minimum 🞏 | | | |