

HESWALL & PENSBY GROUP PRACTICE

APPLICATION FOR PATIENT ONLINE SERVICES

Surname		Forename(s)	
Street		DOB	
Town or city		Postcode	
Phone number		Mobile	
Email			
I wish to have access to the following information (tick which apply):			
Requesting repeat prescriptions			
Viewing summary information including allergies, medication, immunisations & test results			
Documents (available from date of registration)			

I wish to access my health record online and understand and agree with 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 see or download.	
If I choose to share my information with anyone else, this is at my own risk.	
If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible.	
If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible.	
If I think that I may come under pressure to give access to someone else unwillingly, I will contact the practice as soon as possible.	
Signature	
Date	

I can confirm have provided 2 forms of ID (Passport, Driving licence, utility bill)

**THIS FORM MUST BE PRESENTED TO THE RECEPTION DESK FOR THE
RECEPTIONIST TO VERIFY YOUR ID**

For practice use only

Patient NHS number		Practice computer ID number	
Identity verified by (initials)	Date	Method	
		Vouching <input type="checkbox"/> Vouching with information in record <input type="checkbox"/> Photo ID and proof of residence <input type="checkbox"/>	
Authorised by			Date
Date account created			