

Application form for online access to Spencer Street Surgery's online services

Surname		Date of birth
First name		
Address		
Postcode		
Email address		
Telephone number	Mobile number	
<p>I understand that my email address and/or mobile number may be used by the practice to contact you to provide health and care services. For example:-</p> <ul style="list-style-type: none"> • appointment reminders, • health campaign messages • messages relating to your own health and care e.g. test results <p>If you do not wish to be contacted by either of the following please tick</p> <p>Email <input type="checkbox"/></p> <p>Mobile <input type="checkbox"/></p> <p>I wish to have access to the following online services (please tick all that apply):</p>		
1. Booking appointments	<input type="checkbox"/>	
2. Requesting repeat prescriptions	<input type="checkbox"/>	
3. Access to my basic medical record	<input type="checkbox"/>	
4. Access to detailed medical record	<input type="checkbox"/>	
I wish to access my online services and understand and agree with each statement (tick)		
1. I have read and understood the information 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. If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible	<input type="checkbox"/>	
5. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible	<input type="checkbox"/>	
6. 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.	<input type="checkbox"/>	
Signature	Date	
For practice use only		
Patient NHS/EMIS number		
Identity verified by (initials)	Method used	Personal Vouching <input type="checkbox"/> Vouching with information in record <input type="checkbox"/> Photo ID and proof of residence <input type="checkbox"/>
Date account created		
Date login credentials emailed/given		

<p>Level of record access enabled</p> <p style="text-align: right;">Detailed coded record <input type="checkbox"/></p> <p style="text-align: right;">All prospective <input type="checkbox"/></p> <p style="text-align: right;">All retrospective <input type="checkbox"/></p>	<p>Notes / explanation</p>
<p>Date clinical assurance completed</p>	<p>Assured by (initials)</p>
<p>Reason for refusal if record access is refused after clinical assurance.</p>	