Claremont Bank Surgery, Patient Access Request Form

TITLE/ FIRST NAME/ SURNAME	
EMAIL (PLEASE PRINT)	
DATE OF BIRTH	
ADDRESS	
TELEPHONE (HOME /MOBILE)	

I wish to have access to the following online services (tick all that apply): up to 16 years

1) Booking appointments	☐
2) Requesting repeat prescriptions	☐

Application for online access to my medical record *(AVAILABLE FOR PATIENTS OVER 18 ONLY*

PLEASE TICK TEST RESULTS ☐ PROBLEMS ☐ IMMUNISATIONS ☐ ALLERGIES ☐

Patient Access is available for patients aged 16 and over. Parents can register for their children up to 12. Once they reach 12 we will suspend this access until they reach 16. This is in line with our child safeguarding policy.

I wish to access my medical record online and understand and agree with each statement (tick)

over 18 years

1) I have read and understood the information leaflet provided by the practice	☐
2) I will be responsible for the security of information that I see or download	☐
3) If I choose to share my information with anyone else, this is at my own risk	☐
4) I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement.	☐
5) If I see information in my record that is not about me, or is inaccurate I will log out immediately and contact the practice as soon as possible	☐
6) If I think that I may come under pressure to give access to someone else unwittingly I will contact the practice as soon as possible.	☐
SIGNATURE:	**DATE**

OFFICE USE ONLY:

Authorised by: Int Signed	Photo ID ☐ Proof of Residence ☐ Vouching ☐	Date:

THIS FORM MUST BE GIVEN TO RECEPTION BY THE PATIENT THEMSELVES (WHEN AGED 18+) WITH ID. ALL PATIENTS AGED 18 AND ABOVE MUST COLLECT THE REGISTRATION FORM THEMSELVES.

YOUR REGISTRATION FORM WILL BE READY 10-14 WORKING DAYS

IF NOT COLLECTED AFTER 8 WEEKS IT WILL BE NO LONGER AVAILABLE AND A NEW APPLICATION WILL HAVE TO BE MADE