# Application for Online AccessDowns Way Medical Practice

To apply for this service please complete this form and return it to the Surgery in person. You will need to bring photo ID\* and proof of address^. You will need an individual e mail address to apply for the service. Registration details will be e mailed to you. **Please note they expire one month after issue, so if you haven’t activated it by then, you will need to reapply.** If you require online access to Detailed Medical Records, ask for the additional form.

*\*ID needs to show a current photo and signature, eg Current Passport or Driving Licence*

*^ Photocopies will be taken and kept on file*

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

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

|  |  |
| --- | --- |
| 1. Booking appointments | 🞏 |
| 1. Requesting repeat prescriptions | 🞏 |
| 1. Accessing my Online Summary (Medications & Allergies) **(#93440)** | 🞏 |

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

|  |  |
| --- | --- |
| 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 is not about me or is inaccurate, I will contact the practice as soon as possible | 🞏 |
| 1. I agree to be added to the Patient Group to receive information and surveys about the Practice | 🞏 |

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

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

## For practice use only

|  |  |  |  |
| --- | --- | --- | --- |
| Patient NHS number | | Vision ID number | |
| Identity verified by  (initials) | Date | Method  Vouching 🞏  Vouching with information in record 🞏  **Photo ID and proof of residence 🞏** | |
| Authorised by  **(#91B)** | | | Date |
| Date account created | | | |
| Date registration letter/token sent | | | |
| Level of record access enabled Contractual minimum 🞏 | | | |