The Woodlands Practice

Patient Online Access Registration Form

A separate form must be completed for each person

Surname			
First name			
Date of birth			
Address			
Postcode			
Email address			
Telephone number		**Mobile number**	

Application for online access to my medical record

I wish to have access to the following online services (tick any you wish to apply for):

1. Booking appointments	☐
2. Requesting repeat prescriptions	☐
3. Accessing my medical record	☐

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

1. I have read and understood the information leaflet provided by the practice	☐
2. I will be responsible for the security of the 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	☐

Signature		Date	

For practice use only

Identity verified through (tick all that apply) Passport ☐ Driving Licence ☐ Other ☐ (please state document viewed) ____________________	Initials of verifier:	Date:
Clinician who reviewed application (if applicable) Date:	**Outcome of application:** Full access granted (medical record reviewed) ☐ Full access declined (state reason below) ☐ Partial access granted ☐ (Please state approved access)	
Date patient informed of outcome:	Date account created:	