**Consent to Access GP Online Services**

**Personal Details**

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| First Name: | Date or Birth: |
| Surname: |  |
| Address: |
| Email Address: |
| Telephone Number: | Mobile Number: |
| Preferred Contact Method (**please circle**): Email Letter Telephone Text  |

**Repeat Prescriptions**

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| My nominated pharmacy is: |

**Online Services**

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| **I wish to have access to the following online services (please tick all that apply):** |
| 1. Online appointment booking
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| 1. Online prescription requests
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| 1. Full medical records
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| **I wish to access my medical records online and understand and agree to each of the following statements (please tick all that apply):** |
| 1. I will be responsible for the security of the information that I see or download.
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| 1. I will contact the Practice as soon as possible if I suspect that the account has been accessed by someone without my agreement.
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| 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. I will treat any information which is not about me as strictly confidential.
 |  |
| Signature: | Date: |

**Patient Consent**

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| I consent to the practice providing me with the online facility to book/cancel appointments and order repeat prescriptions through SystmOnline. It is my responsibility to keep my account secure by keeping my log in details confidential. I understand that I can terminate my account at any time by contacting the Practice or change my log in details by re-registering. I understand that this form will be kept on my electronic medical record. I will use this service responsibly and in the case of any abuse of the service, Bankfield Surgery can remove my access. Examples of irresponsible use of the service include failure to attend appointments or repeat booking or cancelling of appointments. I understand the practice is committed to protecting my privacy online and that the personal information I enter is strictly controlled using a secure website. Information entered is available only to staff members at Bankfield Surgery with appropriate access rights and is strictly controlled and monitored. ***Personal information will NOT be shared or sold to any third parties.*** |
| Signature: | Date: |

**For Practice Use Only**

**Identification Required - Photo ID and Proof of Residence**

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| **One of the following forms of photo identification can be accepted:**Photocard Driving Licence Passport Bus Pass NHS/College/School Card (Please circle) |
| **Proof of residence (please specify):**  |
| Patient NHS No: | Identity verified by (Initials): | Date: |
| **For Admin Use Only** |
| Method of Verification: Vouching Vouching with information in the record Photo ID and proof of residence |
| Date account created/updated: | Date password sent: |