ATHERSTONE SURGERY

Patient application for advanced access to online services

|  |  |
| --- | --- |
| Surname  | Date of birth |
| First name  |
| Address Postcode |
| Email address  |
| Telephone number  | Mobile number:Consent to receive text messages: Yes/No |

**By filling out this form I am confirming that I wish to receive advanced access to my medical records online prior to the date of 1st November 2023**

I understand and agree with each statement below (tick)

|  |  |
| --- | --- |
| 1. I will be responsible for the security of the information 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 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 consent to receive text messages from the practice for appointment reminders and health promotion
 |  |
| 1. I will be responsible for informing the practice of any changes to my mobile telephone number
 |  |

|  |  |
| --- | --- |
| Patient’s Signature  | Date  |

**For practice use only**

|  |  |
| --- | --- |
| **Patient NHS number** | **Practice computer ID number** |
| **Identity verified by (initials)** | **Date**  | **Method**  **Vouching** **Vouching with information in record** **Photo ID and proof of residence** |
| **Authorised by** | **Date**  |
| **Doctor authorisation signature** | **Date** |

**THIS FORM MUST BE SIGNED AND APPROVED BY THE PATIENTS DOCTOR!!**