MOUNT FARM SURGERY

Lawson Place, Bury St. Edmunds, Suffolk IP32 7EW

Application for Online Services

SURNAME:	**FIRST NAME:**
DATE OF BIRTH:	
ADDRESS:	
EMAIL ADDRESS: PATIENT OR PROXY	
TELEPHONE NO.	**MOBILE NO.**

NAME OF PROXY (IF APPLICABLE) **D.O.B OF PROXY**	**SIGNATURE OF PROXY (IF APPLICABLE)**	**RELATIONSHIP TO PATIENT:**

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

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

If we grant you online access is there the possibility that someone else may access your record without your permission or against your wishes (coercion) (please tick): YES ☐

NO ☐

I wish to access the online services, and understand and agree with each statement (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 contact the practice as soon as possible	☐
SIGNATURE:	

SECTION 2 : FOR PRACTICE USE ONLY

<table>
<tr><td>NHS NUMBER:</td><td colspan="2"></td></tr>
<tr><td>IDENTITY VERIFIED BY:

_____

AUTHORISED BY:

_____

DATE: _____</td><td>DATE:</td><td>METHOD (please tick):

VOUCHING ☐

VOUCHING WITH INFORMATION IN RECORD ☐

PHOTO ID AND PROOF OF RESIDENCE ☐</td></tr>
<tr><td>DATE ACCOUNT CREATED:</td><td colspan="2"></td></tr>
<tr><td>DATE PASSPHRASE GIVEN:</td><td colspan="2"></td></tr>
<tr><td>LEVEL OF ACCESS ENABLED:

PROSPECTIVE ☐
RETROSPECTIVE ☐
ALL ☐
LIMITED PARTS ☐
CONTRACTUAL MINIMUM ☐</td><td colspan="2">NOTES/EXPLANATION:

CHECK DATE ☐</td></tr>
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