



THE HAVEN PRACTICE

Patient Online Registration Form Access to GP Online Services 5 to 10 Years

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

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

Booking Appointments	<input type="checkbox"/>
Requesting Repeat Prescriptions	<input type="checkbox"/>
Accessing Detailed Coded Read Access Excluding Free Text, Letters and Documents	<input type="checkbox"/>

Application for Online Access to My Medical Record

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

❖ I have read and understood the information on the reverse of this form	<input type="checkbox"/>
❖ I will be responsible for the security of the information that I see or download	<input type="checkbox"/>
❖ If I choose to share my information with anyone else, this is at my own risk	<input type="checkbox"/>
❖ I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	<input type="checkbox"/>
❖ If I see information in my record that it not about me, or is inaccurate I will log out immediately and contact the practice as soon as possible	<input type="checkbox"/>

Signature Parent/Guardian		Date	
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For practice use only

Identity verified through (tick all that apply)	Vouching <input type="checkbox"/> Vouching with information in record <input type="checkbox"/> Photo ID <input type="checkbox"/> Proof of residence <input type="checkbox"/>	Name of verifier	Date
Name of person who authorised (if applicable)			Date