BARKING MEDICAL GROUP PRACTICE

Application for Online Access

PLEASE COMPLETE YOUR EMAIL ADDRESS CLEARLY AND IN CAPITAL LETTER

Surname	Date of birth
First name	
Address Postcode	
Preferred Email address (not shared):	
Telephone number	Preferred Mobile number

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 Online Summary (Medications & Allergies) **(#93440)**	☐
4. Access to My Medical Record Online – ask Reception for application form	☐

I wish to use Online Services. Please read each statement carefully and tick before signing.

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	☐

I understand and agree with all the above statements:

Signature	Date

For practice use only

Patient NHS number		EMIS ID number
Identity verified by (initials)	Date	Method Vouching ☐ Vouching with information in record ☐ **Photo ID and proof of residence ☐**
Authorised by **(#91B)**		Date
Date account created		
Date registration letter/token sent		
Level of record access enabled		Contractual minimum ☐