



Chipping Norton Health Centre

Patient Online: Registration Form

Surname			
First name			
Date of birth			
Address			
Email address			
Telephone No.		Mobile No.	

Access to GP online services

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

1. Booking appointments	<input type="checkbox"/>
2. Requesting repeat prescriptions	<input type="checkbox"/>
3. Accessing my medical record	<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)

1. I have read and understood the information leaflet provided by the practice	<input type="checkbox"/>
2. I will be responsible for the security of the information that I see or download	<input type="checkbox"/>
3. If I choose to share my information with anyone else, this is at my own risk	<input type="checkbox"/>
4. 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"/>
5. 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		Date	
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For practice use only

Identity verified (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 / Authoriser		Date	
Date account created		Date registration letter sent / emailed	
Passed for scanning	<input type="checkbox"/>	GP agreed access to detailed record	Y N
Notes / data summarised			