

## Red Practice Whitefriars Surgery

### Application for Online Access

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. Requesting repeat prescriptions	<input type="checkbox"/>
2. Future additional online services	<input type="checkbox"/>

**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	<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 is not about me or is inaccurate, I will contact the practice as soon as possible	<input type="checkbox"/>

**I understand and agree with all the above statements:**

Signature	Date
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### For practice use only

Patient NHS number	Vision ID number	
Identity verified by (initials)	Date	Method Vouching <input type="checkbox"/> Vouching with information in record <input type="checkbox"/> Photo ID <input type="checkbox"/>
Authorised by (#91B)	Date	
Date account created		
Date registration email sent		