# The Snaith & Rawcliffe Medical Group

**Application for online access**

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

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

|  |  |
| --- | --- |
| I am aged 16 years or above and I am requesting access for the following:- |  |
| I am aged 12-15 and I am requesting access to my own online services (**GP Consent Required**) |  |
| Booking Appointments |  |
| Requesting repeat prescriptions |  |

**I wish to access my online serivices and understand and agree with each statement (tick)**

|  |  |
| --- | --- |
| I have read and understood the information leaflet provided by the practice |  |
| I will be responsible for the security of the information that I see or download |  |
| If I choose to share my information with anyone else, this is at my own risk |  |
| If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible |  |
| If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible |  |
| If I think that I may come under pressure to give access to someone else unwillingly I will contact the practice as soon as possible.  |  |
| **Consent:-** |  |

# For practice use only

Signature

Date

|  |  |
| --- | --- |
| Patient NHS number | Practice computer ID number |
| Identity verified by (initials) | Date | MethodVouching Vouching with information in record Photo ID and proof of residence  |
| Authorised by | Date |

|  |
| --- |
| **GP Use for patients aged between 12 – 15 years:**I have assessed the applicant for Gillick Competence in managing their own health care and have recorded the appropriate code in the patients’ record. |
| **GP Name:** |
| **Signature of GP:** |
| **Date:** |