# The Snaith & Rawcliffe Medical Group

# Application for online access

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| --- | --- | --- | --- |
| **Surname** | **Date of birth** | | |
| **First name** | | | |
| **Address**  **Postcode** | | | |
| **Email address** | | | |
| **Telephone number** | | **Mobile number** | |
|  | |  | |
| I am happy to receive appointment updates via text message | | |  | |
| I am happy to receive email notification | | |  | |
| I am happy to use online Triage | | |  | |

**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 services 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:-**  Signature  Date |  |

# For practice use only

|  |  |  |  |
| --- | --- | --- | --- |
| Patient NHS number | | Practice computer ID number | |
| Identity verified by (initials) | Date | Method  Vouching   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:** |