

University of Reading Medical Practice

Registration form for Access to GP online services

Surname			
First name			
Date of birth			
Address			
Email address			
Telephone number		Mobile number	

PARENTS/GUARDIANS
 If you are requesting access on behalf of a child (*up to 13 years#*) or for a patient whom you have legal responsibility please give your details below:

Name of Parent/Guardian:
 Address of Parent/Guardian:

Contact Tel Number:
 Relationship to patient:

Please note that access for the child will be revoked when they reach 13 years of age. They will need to sign their own request form.

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

1. Booking appointments – allows you to book and cancel 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

Emis No:		Date	
ID Seen:	Passport/Driving Licence/Other (Please specify)		
Taken by:		Actioned:	Yes/No