Forest House Surgery

**Application for Systmone online access**

|  |  |
| --- | --- |
| Surname | Date of Birth |
| Name |
| Address Post Code  |
| Email Address |
| Telephone Number | Mobile Number |

By registering for online facilities I understand I will have access to all of the following:

|  |  |
| --- | --- |
|  | PLEASE TICK |
| 1. Booking appointments.
 |  |
| 1. Requesting repeat prescriptions.
 |  |
| 1. Accessing my latest summary care record (Current medication, allergies, adverse reactions).
 |  |

I wish to access my summary care record online and understand and agree with each statement (please tick the following)

|  |  |
| --- | --- |
| 1. I will be responsible for the security of the information that I see or download.
 |  |
| 1. If I choose to share my information with anyone else, this is at my own risk.
 |  |
| 1. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement.
 |  |
| 1. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible.
 |  |

Failure to agree to all of the above conditions will unfortunately mean we are unable to agree to your request to access.

|  |  |
| --- | --- |
| Signature | Date |

**For Practice use only**

|  |  |
| --- | --- |
| Patient NHS Number |  |
| Identity verified by(Name) | MethodPassport/Driving LicenseNon-Photo IDProof of residenceParent ID (under 14) |
| Date account created |

Once completed please register the patient for ‘systmonline’ and then pass this form to clerks for scanning on to patient record.