Forest House Surgery

**Application for Systmone online access**

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| --- |
| Surname I Date of birth |
| First name |
| AddressPostcode |
| Email address |
| Teleohone number I Mobile number |

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

|  |  |
| --- | --- |
| 1. Bookina annointments | □ |
| 2. Reauestina repeat prescriptions | □ |
| 3. Accessing my brief 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)

|  |  |
| --- | --- |
| 4. I will be resoonsible for the securitv of the information that I see or.download | □ |
| 5. If I choose to share mv information with anvone else, this is at mv own risk | □ |
| 6. I will contact the practice as soon as possible if I suspect that my accounthas been accessed bv someone without mv aareement | □ |
| 7. If I see information in my record that is not abayt me or is inaccurate, I willcontact 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 for access.

I Signature I Date

**For practice use only**

|  |  |
| --- | --- |
| Patient NHS number |  |
| Identity verified by (Name) | MethodPassport/Driving Licence □Non-Photo ID □ Proof of residence □ Parent 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

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v4 4 February 2015