

Wallingford Medical Practice Application for Basic online access

By completing this form I confirm I would like basic access to online services. By signing the form I adhere to use the system responsibly in accordance with all instructions given to me by my GP practice. I agree to inform my GP practice of any errors /problems I see within my record whilst I use the system.

Surname:	First Name:
Date of Birth:	NHS no (if known):
Address:	
Email:	<i>By giving your email you are consenting to be contacted by email</i>
Home Telephone:	Mobile:

Is this application for you?

Yes No, if no please state below who it is for and the relationship.

Please Note - Access cannot be given for anyone aged 11 – 16 years. If you have any questions regarding this please contact the surgery and speak to Debra Perry/Andrew Knight

By completing this form you are asking for access to the following online services -

Booking Appointments

Requesting repeat prescriptions

Changing my contact information

Should you also wish to view your medical history information online, please complete the Online access (advanced access) form which can be found on our website or you can ask reception.

I confirm I have read the information leaflet provided by the surgery and agree to be responsible for the security of the information that I see or download. I understand that if I choose to share my information with anyone else, this is at my own risk. I understand that I should contact the practice as soon as possible if I suspect my account has been accessed without my permission or unlawfully. I understand I will contact the practice should I see information that is not about me or is incorrect.

Signed: _____ Name(printed): _____

Practice use only

Identity verified by: _____ Method: Vouching/Photo ID & proof of address (please delete)

ID Seen: Passport/driving license/Bank statement/Utility Bill (please delete as appropriate)

Authorised by: _____ Date: _____