# Application for Online Access for Appointments & Prescriptions

|  |  |
| --- | --- |
| Surname | Date of birth |
| First name | |
| Address          Postcode | |
| Preferred Email address (not shared): | |
| Preferred telephone number (ideally mobile) | For security please list a medication that you are prescribed |

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

|  |  |
| --- | --- |
| 1. Booking / cancelling / viewing appointments | 🞏 |
| 1. Requesting repeat prescriptions | 🞏 |
| 1. Requesting acute prescriptions | 🞏 |

**I wish to use Online Services. Please read each statement carefully and tick before signing.**

|  |  |
| --- | --- |
| 1. I have understood the information provided by the practice | 🞏 |
| 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 | 🞏 |

**Text consent. This allows us to send you reminders of appointments 48 hours in advance and to contact you occasionally regarding your medical treatment.**

|  |  |
| --- | --- |
| I consent to receiving texts from Colinton Surgery regarding my medical treatment. | 🞏 |

**I understand and agree with all the above statements:**

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

### For practice use only

|  |  |  |
| --- | --- | --- |
| Patient CHI number | Vision ID number | |
| Authorised by  **(#91B)** | | Date |
| Date registration letter/email sent | | |