FIRRHILL MEDICAL CENTRE

Application for Online Access

Surname	Date of birth
First name	
Address Postcode	
Preferred Email address: **PLEASE USE CAPITAL LETTERS**	
Telephone number 0 1 3 1	Preferred Mobile number. 0 7

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

1. Cancelling / viewing appointments **(not yet available but please complete as may be available in the near future)**	☐
2. Requesting repeat prescriptions	☐
3. 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	☐
2. I will be responsible for the security of the information that I see or download	☐
3. If I choose to share my information with anyone else, this is at my own risk	☐
4. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	☐
5. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible	☐

Children aged 12-16.

If you are aged 12-16 and you wish to continue using your parent's mobile number/email, please tick this box and we will contact you again when you turn 16	☐

I understand and agree with all the above statements:

Signature	Date

For practice use only

Patient CHI number		Vision ID number
Identity verified by (initials)	Date	Method Vouching ☐ Vouching with information in record ☐ **Photo ID and proof of residence ☐**
Authorised by **(#91B)**		Date
Date account created.		
Date registration letter/email sent		