GUARDIAN MEDICAL CENTRE

Online Services Registration Form

Personal Details:

Name: ____

Date of Birth: ____

Address: ____

____

Postcode: ______________________________

Landline Telephone: ______________________________

Mobile Telephone: ______________________________

Email Address: ______________________________

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

1. Appointment Booking ☐
2. Medication Requesting ☐
3. Summary Record Access ☐
4. Detailed Coded Record Access ☐

Application for online access to my medical record

I wish to access my medical record online and understand and agree with each statement (please tick)

1. I have read and understood the information leaflet 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, that 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 log out immediately and contact the practice as soon as possible ☐

Signature:____________________________ **Date:** ______/______/______

For Practice use only:

Identification Provided:	
Photo identification Type: ______________________ Number:______________________	**Proof of address** Type: ______________________ Issuer: ______________________ Date: ______/______/______
Staff verification + Access Granted:	
Staff Name Name: ______________________ Date: ______/______/______	**Access Granted** Appointment Booking ☐ Medication Requesting ☐ Summary Record Access ☐
Detailed coded record (management only):	
Manager Name Name: ______________________ Date: ______/______/______	**Detailed Coded Access** Detailed Coded Record Granted ☐ Detailed Coded Record NOT Granted ☐ *(Please Give Reason)*______________________