Portobello and Conan Doyle Surgeries **Dr A Comiskey & Partners**

Application for Online Access

Surname	Date of birth
First name	
Address Postcode	
Preferred Email address (not shared):	
Telephone number	Preferred Mobile number

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

1. Booking / cancelling / viewing appointments (not available at present)	☐
2. Requesting repeat prescriptions	☐
3. Requesting acute prescriptions	☐
4. Accessing my Online Summary (Medications & Allergies) (not available at present)	☐

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	☐

Consent please write yes or no (do not tick)

1. Contact by email	please choose
2. Contact by text	please choose
3. Sharing of records with secondary care (hospital, ambulance etc)	please choose

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 Personal Vouching ☐ Vouching with information in record ☐ **Photo ID and proof of residence ☐**
Authorised by **(#91B)**		Date
Date account created		