



Cumbria Health on Call

Glenridding Health Centre

Application form for online access to the practice online services

Surname		Date of birth	
First name			
Address			
Postcode			
Email address			
Telephone number		Mobile number	
<p>I understand that my email address and/or mobile number may be used by the practice to contact you to provide health and care services. For example:-</p> <ul style="list-style-type: none"> • appointment reminders, • health campaign messages • messages relating to your own health and care e.g. test results <p>If you do not wish to be contacted by either of the following please tick</p> <p>Email <input type="checkbox"/></p> <p>Mobile <input type="checkbox"/></p> <p>I wish to have access to the following online services (please tick all that apply):</p>			
1. Booking appointments			<input type="checkbox"/>
2. Requesting repeat prescriptions			<input type="checkbox"/>
3. Access to my basic medical record			<input type="checkbox"/>
4. Access to detailed medical record			<input type="checkbox"/>
I wish to access my online services and understand and agree with each statement (tick)			
1. I have read and understood the information provided by the practice			<input type="checkbox"/>
2. I will be responsible for the security of the information that I see or download			<input type="checkbox"/>
3. If I choose to share my information with anyone else, this is at my own risk			<input type="checkbox"/>
4. If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible			<input type="checkbox"/>
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			<input type="checkbox"/>
6. If I think that I may come under pressure to give access to someone else unwillingly I will contact the practice as soon as possible.			<input type="checkbox"/>
Signature		Date	
For practice use only			
Patient NHS/EMIS number			
Identity verified by (initials)		Method used Personal Vouching <input type="checkbox"/> Vouching with information in record <input type="checkbox"/> Photo ID and proof of residence <input type="checkbox"/>	

Date account created	
Date login credentials emailed/given	
Level of record access enabled Detailed coded record <input type="checkbox"/> All prospective <input type="checkbox"/> All retrospective <input type="checkbox"/>	Notes / explanation
Date clinical assurance completed	Assured by (initials)
Reason for refusal if record access is refused after clinical assurance.	