**Garden City Surgery**

**Online Services- Registration form**

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| Patient’s title and full name: |  |
| *Patient’s full address:* | Postcode: |
| *Patient’s Date of birth:* |  |
| *Patient’s Email address (this require verification):* |  |
| *Patient’s Contact Mobile and Landline phone number:* |  |
| I would like to Opt-in to have prospective access to my full GP records from the date of this form. Please Tick the YES or NO | |
| ***Details of Parents/ Guardian/Carer, requesting Proxy access including Full name and relation to the patients of under 16years old:***  ***Full name : D.O.B:***  ***Relationship with the patients:***  ***Parents/ Guardian/Carer*** | |
| ***Please note that we will require to see original copies of your ID documents (Passport, Full Driving Licence) to confirm your identity.*** | |
| ***Once you complete and emailed this form, Please give 48/72 hours for the practice to get in touch with you.*** | |