University Medical Group

Registration form for Access to GP online services

Surname			
First name			
Date of birth			
Address			
Email address			
Telephone number		Mobile number	

PARENTS/GUARDIANS
If you are requesting access on behalf of a child *(up to 11 years#)* or for a patient whom you have legal responsibility please give your details below:

Name of Parent/Guardian:
Address of Parent/Guardian:

Contact Tel Number:
Relationship to patient:

Please note that access for the child will be revoked when they reach 11 years of age. They will need to sign their own request form.

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

1. Booking appointments – allows you to book and cancel appointments	☐
2. Requesting repeat prescriptions	☐
3. Accessing my medical record	☐

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, 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 it not about me, or is inaccurate I will log out immediately and contact the practice as soon as possible	☐
6. I consent to have my user details communicated by email	☐

Signature		Date	

For practice use only

Emis No:		Date	
ID Seen: (2 forms of ID required)	Passport/Driving Licence/Other – utility bills not accepted (Please specify)		
Taken by:		Actioned:	Yes/No