# NEWQUAY HEALTH CENTRE

**PLEASE NOTE: PHOTO ID IS REQUIRED WHEN REGISTERING FOR ONLINE SERVICES.**

**You will need your own personal email address to sign up.**

|  |  |
| --- | --- |
| Surname |  |
| First name |  |
| Date of birth |  |
| Address + Post code |  |
| Email addressPersonal (unique) |  |
| Telephone number |  | Mobile number |  |

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

|  |  |
| --- | --- |
| 1. Requesting repeat prescriptions
 | 🞏 |
| 1. Booking appointments
 | 🞏 |
| 1. Accessing my medical record
 | 🞏 |

# Application for online access to my medical record

*Please note: access to the medical record for newly registered patients will not be enabled until the previous GP record has been received by the practice, summarised and reviewed by a GP.*

**I have read the patient information leaflet and wish to access my medical record online.**

**I understand and agree with each of the following statements (please tick)**

|  |  |
| --- | --- |
| 1. I have read and understood the information leaflet provided by the practice
 | 🞏 |
| 1. I will be responsible for the security of the information that I see or download
 | 🞏 |
| 1. If I choose to share my information with anyone else, this is at my own risk
 | 🞏 |
| 1. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement
 | 🞏 |
| 1. 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
 | 🞏 |

|  |  |  |  |
| --- | --- | --- | --- |
| Signature |  | Date |  |

### For practice use only

|  |  |  |  |
| --- | --- | --- | --- |
| Identity verified through(tick all that apply) | Photo ID 🞏Proof of residence 🞏Vouching 🞏Vouching with information in record 🞏  | Name of verifier | Date |
| Name of person who authorised (if applicable) |  | Date |
| Practice copy 🞏 | Patient copy 🞏 |