**The Glen Medical Practice**

**Application for Online Access**

**PLEASE PRINT CLEARLY – Under 16s unable to Register for Online Access**

|  |  |
| --- | --- |
| Surname: | Date of birth: |
| First name: |
| Address:   Postcode:  |
| Preferred Email address (not shared):  |
| Telephone number: | Preferred Mobile number:Consent To Receive SMS (not shared):  |

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

|  |  |
| --- | --- |
| Requesting repeat prescriptions | 🞏 |
| Requesting acute prescriptions | 🞏 |

**I wish to use Online Services. Please read each statement carefully and tick before signing.**

|  |  |
| --- | --- |
| I have understood the information provided by the practice | 🞏 |
| I will be responsible for the security of the information that I see or download | 🞏 |
| If I choose to share my information with anyone else, this is at my own risk | 🞏 |
| I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement | 🞏 |
| If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible | 🞏 |

**I understand and agree with all the above statements:**

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

**For practice use only**

