# Application for Systmone online access

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

## By registering for online facilities I understand I will have access to all of the following:

|  |  |
| --- | --- |
| 1. Booking appointments
 | 🞏 |
| 1. Requesting repeat prescriptions
 | 🞏 |
| 1. Accessing my brief summary care record (Current medication, allergies, adverse reactions)
 | 🞏 |
| 1. Accessing my medical consultations plus communications and letters (including attachments) and free text since 30/10/23 or date of surgery registration if after 30/10/23
 | 🞏 |

I wish to access my summary care record online and understand and agree with each statement

(please tick the following)

|  |  |
| --- | --- |
| 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 is not about me or is inaccurate, I will contact the practice as soon as possible
 | 🞏 |

Failure to agree to all of the above conditions will unfortunately mean we are unable to agree

to your request for access.

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

### For practice use only

|  |  |
| --- | --- |
| Patient NHS number |  |
| Identity verified by(Name) | MethodPassport/Driving Licence 🞏 Non-Photo ID 🞏 Proof of residence 🞏Parent ID (Under 14) 🞏 |
| Date account created  |

Once completed please register the patient for ‘systmonline’ and then pass this form to clerks for scanning on to patient record