Alresford Surgery

Application for basic online access to my medical record

Section 1

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

Section 2

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

1. Booking appointments	☐
2. Requesting repeat prescriptions	☐
3. Access to allergies, medications & immunisations.	☐

Section 3

I agree for my mobile number & email address to be used by the Surgery as a form of communication.	☐

Signature.....	Date.....

Please print, sign & return the form to the Surgery in person, with your **identification** in order to collect your registration letter for Patient Access.

For practice use only

Patient NHS number:		Practice computer ID number:
Identity verified by (initials)	Date	Method Vouching ☐ Vouching with information in record ☐ Photo ID and proof of residence ☐
Authorised by:		Date:
Date account created:		