# chmc3

**Application to make online appointments and request repeat medication for age 16 and over only.**

**PLEASE BRING PHOTO ID WITH THIS FORM.**

**Please print clearly**

|  |  |
| --- | --- |
| First name |  |
| Surname |  |
| Date of birth |  |
| Address with post code |  |
| Telephone number | Landline: Mobile: |
| SMS Texting | I give permission for CHMC to contact me by text message Yes No |
| Email address |  |

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

|  |  |
| --- | --- |
| Booking appointments |  |
| Requesting repeat prescriptions |  |

I wish to have access to online services as above and understand and agree with each statement (tick to confirm read and agree)

|  |  |
| --- | --- |
| 1. I have read and understood the information on the reverse of this form |  |
| 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. If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible |  |
| 5. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible |  |
| 6. If I think that I may come under pressure to give access to someone else unwillingly I will contact the practice as soon as possible. |  |
| I give my consent for Clifton House Medical Centre to send text message notifications to my mobile telephone and emails to the address I have supplied above. **I understand it is my responsibility to inform them of any changes to the details I have provided above.**  Patient Signature  Date |  |

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# Important Information – Please read before returning this form

**It will be your responsibility to keep your login details and password safe and secure. If you know or suspect that your record has been accessed by someone that you have not agreed should see it, then you should change your password immediately.**

If you cannot do this for some reason, we recommend that you contact the practice so that they can remove online access until you are able to reset your password.

**If you print out any information from your record, it is also your responsibility to keep this secure. If you are at all worried about keeping printed copies safe, we recommend that you do not make copies at all.**

For more information about keeping your healthcare records safe and secure please visit our website: [www.cliftonhousemedicalcentre.co.uk](http://www.cliftonhousemedicalcentre.co.uk)

# For practice use only

|  |  |  |  |
| --- | --- | --- | --- |
| Identity verified by (initials) | Date | Method  Vouching   Vouching with information in record   Photo ID and proof of residence  | |
| Authorised by | | | Date |
| Date account created | | | |
| Date passphrase sent | | | |