# **ALYTH HEALTH CENTRE**

# **Application for online services (over 16s only)**

|  |  |
| --- | --- |
| Surname | Date of birth |
| First name |
| Address  Postcode  |
| Preferred Email address write clearly:-**Shared/not shared** (please circle) |
| Telephone number | Preferred Mobile number |

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

|  |  |
| --- | --- |
| 1. Booking appointments
 | 🞏 |
| 1. Requesting repeat prescriptions
 | 🞏 |
| 1. Requesting acute prescriptions
 | 🞏 |
| 1. Accessing my online summary (medications & allergies)
 | 🞏 |

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

|  |  |
| --- | --- |
| 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
 | 🞏 |

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

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

To register for this service please bring two forms of identification, one being picture ID i.e. passport, drivers licence or bus pass and a recent utility bill with your name and address on it. Once we have all your information you will be sent an e mail with the information codes that you require to set up your account. You have 28 days to set your account up, if you should be outwith these days, present at reception and we will reset your account.

For practice use only

|  |
| --- |
| Patient CHI Number |
| Identity verified by(initials) | Date | Photo ID 🞏Proof of residence 🞏 |
| Authorised by   **(#91B)** | Date |
| Date registration letter/token sent  |