Patient Access Application Form

Patient To Complete

Name:	
D.O.B:	
Address:	
Tel No:	
Mob No:	
Practice Guidance read and understood:	Delete as appropriate **Yes/No**

Surgery Staff Only

Proof of photographic ID given e.g passport, driving license:	Yes/No
Identity confirmed:	Yes/No Signed

I have understood and will adhere to the Practice Guidance for the use of Patient Access. I understand that failure on my part to adhere to the guidance may result in my Patient Access registration being terminated. I understand that this will in no way affect my registration with the practice. I also acknowledge that the practice will send me text reminders and request(s) for medical records updates.

Internet communications cannot be guaranteed to be secure or error-free, as information could be intercepted, corrupted, lost, arrive late or contain viruses. It is you responsibility to take all prudent safegaurds.

Signed_____

Date_____