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| *FWHC Logo.jpg*  **Tweeddale Medical Practice** |  |

**Patient Services - Patient registration form**

If you would like to register for this online service please complete the form below and return it to your GP practice in person, by post, via email (see practice website for email address) or via your Community Pharmacy.

Your GP Practice will contact you to process this and provide you will all the relevant information to set up your account.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Patient details Please complete in BLOCK CAPITALS** | | | | | | |
| Patient forename | | | | | | |
| Patient surname | | | | | | |
| Date of birth D D / M M / Y Y Y Y | | | | | | |
| Email address | | | | | | |
| **This email address will be used to send you Patient Services notifications and reminders.** | | | | | | |
| Mobile number | | | | | | |
| Signature | | | | | | |
| Date D D / M M / Y Y Y Y | | | | | | |
| **I wish to access my medical record online and understand and agree with each statement (tick)** | | | | | | |
| 1. I have read and understood the information leaflet provided by the practice | | | | |  |  |
| 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. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement | | | | |  |  |
| 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 | | | | |  |  |
| **Completing the form on behalf of the patient?** | | | | | | |
| Print forename | | | | | | |
| Print surname | | | | | | |
| Relationship to patient | | | | | | |
| Signature | | | | | | |
| Date D D / M M / Y Y Y Y | | | | | | |
| ----------------------------------------------------------------------------------------------------------------------------------------- | | | | | | |
| **Staff use only** | | | | | | |
| Method registration form received | (e.g. via email, via pharmacy bag, in person, etc) | | | | | |
| *Method of identity verification (complete all that apply)* | | | | | | |
| Presentation of documents | List documents seen | | | | | |
| Vouching | List conditions of personal vouch | | | | | |
| Vouching with confirmation | List conditions of vouching with confirmation (e.g. | | | | | |
| ----------------------------------------------------------------------------------------------------------------------------------------------------------- | | | | | | |
| *To be completed where Proxy access has been granted* | | | | | | |
| Basis & evidence for Proxy access | e.g. parent of pt <12yrs, incapacity, etc | | | | | |
| Recall set | e.g. children & Young People | | | | | |
| ----------------------------------------------------------------------------------------------------------------------------------------------------------- | | | | | | |
| Method of providing Patient Services Online Ticket Code | | e.g. in person, posted | | | | |
| Read Code “912P – Registered for online access to local practice” | | |  |
| Staff name | | | | | | |
| Staff Signature | | | | | | |
| Date D D / M M / Y Y Y Y | | | | | | |