Isca Medical Practice

Application for online access

Surname	Date Of Birth
First Name	
Address	
Email Address	
Telephone Number	Mobile Number

I wish to have access to the following (Please tick boxes that apply):

1. Booking appointments	□
2. Requesting repeat medications	□

I also wish to have access to my medical record online and understand and agree with each statement □

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

Signature	Date

For practice use only

Patient identity verified by:	Date	Method: Photo ID □ Proof of residence □
Authorised by:	Date	Date on-line account created:
Level of access to record enabled: Booking appointments □ Repeat Medication □ Summary Care Record □ Coded Entries □		Date password/user name sent:

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