Application for Online Services

For patients 16 and over only

FIRECLAY HEALTH
Your Health is Our Concern

Patient Details

Name:	Date of birth:
Address:	
Email address:	

I wish to have access to:

Book/cancel appointments	☐
Request repeat medication	☐
View my core medical record (medication & allergies)	☐
View immunisations	☐
View test results	☐

More detailed record access requires a further application form - ask at Reception for details

I understand and agree with each of these statements:

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. 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 that is not about me or is inaccurate, I will contact the practice as soon as possible
6. If I am under pressure to give access to someone else unwillingly I will contact the practice as soon as possible

I consent to my registration details being sent to the email address above Yes ☐ No ☐

Signature of patient:	Date:

Identity Verification: Practice use only ***(staff member to complete when giving registration details to patient)***

EMIS ID:	Date:
Identity verified by Staff member name:…… Signature:……	Vouching ☐ (known to staff member) Vouching with additional questions ☐ Photo ID seen ☐ …… 2nd form of ID seen ☐ ……