

Online Services Application Form

- To:
1. Book an appointment with a doctor online
 2. Order repeat prescriptions online
 3. Update your contact details online

In accordance with data protection principles, to enable access to our online services we require you to complete this form. Proof of identity is required.

Name: **DOB:**.....

Address:
.....

Home Tele No: **Mobile Tele No:**.....

Email address:

Please can you let us know if you are happy for us to contact you by email for the following purposes:

Newsletters and general information about the practice? **Yes/ No**

Annual reviews/other medical appointments? **Yes/ No**

I hereby authorise Teams Medical Practice to release registration details to allow me to use online services. I understand that it is my responsibility to ensure that the details are kept safe and secure and not shared with anyone else.

I further agree to use the system in a responsible manner in accordance with all instructions given to me by Teams Medical Practice and to immediately report any errors I encounter whilst using the system.

I am the patient:

I am representing the patient capacity:(e.g. mother)
(When representing a patient over 12 years old a letter of authority signed by them is required)

Signed:

Print Name:

Address if different from above

.....

Date:

For surgery use only	
Identity confirmed	Yes / No
Identity provided e.g. Passport/Driving License	
PIN issued	Yes / No
Form passed for scanning	Yes / No

Please hand form into reception