LAKESIDE HEALTHCARE
at Oundle

Application for Online Access

Patient Details:

First name:	Surname:
Address:	Date of birth:
Telephone number:	Mobile number:
Email address:	

I consent to be contacted by SMS message: YES ☐ NO ☐

I wish to have access to the following online services (please tick all that apply):

1	Booking Appointments	☐
2	Requesting Repeat Prescriptions	☐
3	Accessing my Summary Record View	☐
4	Completing Questionnaires	☐
5	Accessing my Detailed (Coded) Record Set	☐

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	☐
6	I understand that I may view data in my online record that the Doctor has not yet spoken to me about	☐

Patients Signature: _____

For practice use only

Identity verified by (initials): Date:	Method: Vouching ☐ Photo ID ☐ Proof of residence ☐
Date account created:	Authorising Staff Member:
Notes/Explanation:	