



# STANDISH MEDICAL PRACTICE

## Application for online access

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

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

1. Booking appointments	<input type="checkbox"/>
2. Requesting repeat prescriptions	<input type="checkbox"/>

Signature	Date
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Should you wish to request access to information in your medical records  
please speak to the receptionist

### For practice use only

Patient NHS number		Practice computer ID number	
Identity verified by (initials)	Date	Method Vouching <input type="checkbox"/> Vouching with information in record <input type="checkbox"/> Photo ID and proof of residence <input type="checkbox"/>	
Authorised by		Date	
Date account created			
Date passphrase sent			
Level of record access enabled		Notes / explanation	
Prospective <input type="checkbox"/> Retrospective <input type="checkbox"/> All <input type="checkbox"/> Limited parts <input type="checkbox"/> Contractual minimum <input type="checkbox"/>			