Richmond Hill Practice LTD

Online Services Application Form – **ADULT**

PLEASE USE CAPITALS & PRINT CLEARLY	
Full name:	**Date of birth**:
Address:	
Email address: (I am happy to be contacted by email)	
Mobile number: (I am happy to be contacted by mobile)	

Please tick one of the following statements.

1. I do not have an account and would like to view my medical record online ☐
   (This option requires a form of ID)
2. I already have an account, but require further access to my medical record ☐

** If you already have an account and the two options above don't apply, but you are experiencing technical problems, please visit the support page and contact patient access - www.patientaccess.co.uk
DO NOT fill this form in**

I wish to access my medical record online and **understand and agree with each statement**

1. I have read and understood the information leaflet provided by the practice (please visit our website)	☑
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: _____

***** Please allow up to 3 weeks to be processed *****