

**Brook House and Raymond Road Surgeries  
APPLICATION FOR PATIENT ONLINE SERVICES**

Surname		Forename(s)	
Street		Area	
Town or city		Postcode	
Phone number		Mobile	
Email			

I wish to have access to the following information (tick which apply):

Booking appointments	
Requesting repeat prescriptions	
Accessing my medical record	

I wish to access my health record online and understand and agree with the following statements:

I have read and understood the information leaflet provided by the practice.	
I will be responsible for the security of the information that I see or download.	
If I choose to share my information with anyone else, this is at my own risk.	
If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible.	
If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible.	
If I think that I may come under pressure to give access to someone else unwillingly, I will contact the practice as soon as possible.	
Signature	
Date	