GRANTA Medical Practices

SystmOnline Access Adult Application

(patients 16 years and over only)

MY DETAILS

Name: DoB:

Mobile phone number:

Home phone number:

Email address:

Smoking status: Never smoked ❐ Smoker ❐ Ex-smoker ❐

Height: Weight:

ONLINE ACCESS TO RECORDS

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

Booking appointments	❐
Requesting repeat prescriptions	❐
Accessing my Summary Care Record	❐
Detailed Coded Record (test results and coded problems)	❐

I wish to access my medical records online and understand and agree with each statement (please tick):

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	❐
I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	❐
If I see information on my record that is not about me or that is inaccurate I will contact the practice as soon as possible	❐

Signature:

FOR PRACTICE USE ONLY (scan to patient's record)

One document is required to verify identification, and needs to contain a photograph of the patient

Acceptable Documentation:	Tick as applicable Document seen	Number	ID Verified (initials)
Passport	❐		
Driving license	❐		
Other (please specify)	❐		