Coleridge Medical Centre

APPLICATION FOR ONLINE SERVICES, SMS TEXT AND EMAIL
YOU CAN OPT FOR ANY OR ALL OF THE SERVICES AVAILABLE

SURNAME	DATE OF BIRTH
FIRST NAME(S)	
ADDRESS	
POSTCODE	
TELEPHONE NUMBER	MOBILE NUMBER
EMAIL ADDRESS	

I consent to receiving text messages from Coleridge Medical Centre for the purposes of health promotion, practice news and appointment reminders.	YES/NO
I consent to receiving email messages from Coleridge Medical Centre for the purposes of health promotion, practice news and appointment reminders.	YES/NO

I wish to have access to the following online services:-

1. Booking appointments	YES/NO
2. Requesting repeat prescriptions	YES/NO
3. Accessing my medical record	YES/NO

To access these services 2 x forms of ID are required.

For newly registered patients DATE FOR TEXT REMINDER: (MM/YY 3 months forward)

Your application is not complete unless you have read, ticked and signed the declarations on page 2. Please continue on to the page overleaf.

DECLARATION

I wish to access my medical record online and understand and agree with each statement (please tick all that apply).

	TEXT	EMAIL	ONLINE ACCESS
I have read and understood the leaflet called Text, Email and Online Services provided by the practice.			
I acknowledge that appointment reminders by text are an additional service and that they may not be sent on all occasions but that the responsibility for attending or cancelling appointments still rests with me.			
Text messages are generated using a secure facility but I understand that they are transmitted over a public network onto a personal telephone and as such may not be secure. However, the practice will not transmit any information which would enable an individual patient to be identified.			
I understand that it is my responsibility to inform the Coleridge Medical Centre if I change my mobile phone number of email address or no longer have access to either or both.			
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 in my record that is not about me or is inaccurate, I will contact the practice as soon as possible.			

You can withdraw or change your consent at any time by completing and sending in a new form.

SIGNED	DATE