

Application for Online Access for ordering prescriptions (*must be over 16 years old)

Surname	Date of birth
First name	
Address Postcode	Telephone number
Preferred Email address (must be your personal email address not shared with another patient):	
Preferred Mobile number (We can send a text to this number once your online account has been set up only if you have consented to patient text reminders – you can give your consent for this service in the section below)	

I wish to have access to the following online service (please tick/add a cross to box below):

Requesting repeat and/or acute prescriptions	<input type="checkbox"/>
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I wish to use Online Services. Please read each statement carefully and tick/add cross before signing.

1. I have understood the information provided by the practice	<input type="checkbox"/>
2. I will be responsible for the security of the information that I see or download	<input type="checkbox"/>
3. If I choose to share my information with anyone else, this is at my own risk	<input type="checkbox"/>
4. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	<input type="checkbox"/>
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	<input type="checkbox"/>

I understand and agree with all the above statements and consent to the use of my email address for the purpose of setting up an online prescription services account. I am aware that I can update this information or withdraw my consent at any time.

Signature	Date
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I consent to the use of my personal mobile number for patient text messaging (appointment reminders/recalls/online prescriptions account confirmation). I understand that I am responsible for the security of any information received via text message. I am aware that I can update this information or withdraw my consent at any time.

Signature	Date
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My preferred pharmacy is	
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Our **Privacy Policy** can be found on our website <https://www.grangemedicalgroup.com/privacy-policy>

For practice use only

Identity verified by (initials)	Date	Vouching with information in record <input type="checkbox"/> Photo ID and proof of residence <input type="checkbox"/>
Authorised + account created by:		Date
Consent given for text messaging Y/N		