**Access to Online Services Agreement**

If you require any assistance accessing the new online service provider, please use the following web address and this will take you directly to the Guide for Patients: <https://systmonline.tpp-uk.com/2/help/help.html> .

|  |  |
| --- | --- |
| Name:  | Date of Birth: |
| Address: | NHS Number: |
|  | Mobile Number: |
|  | Email Address: |

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

|  |  |
| --- | --- |
| **Service Options** | **Tick (✓)** |
| Request Repeat Medications |  |
| Booking Appointments  |  |
| Full Medical Record from date of Clinical Review |  |
| Questionnaires |  |

|  |  |
| --- | --- |
| **I understand and agree with each of the following statements:-** | **Tick (✓)** |
| I will be responsible for keeping any information that I read, copy, download or print, safe and secure. |  |
| I am completing this form for myself. |  |
| I am competent at using login details to access my online record. |  |
| I agree that if I should decide to share information that it shall be at my own risk. |  |
| If I notice that any information contained within my record is inaccurate or incorrect, I confirm that I will contact the Surgery as soon as possible. |  |
| I agree to contact the Surgery as soon as possible if I suspect that my online account has been accessed by a third party without my permission or if a third party is pressurising me to provide access. |  |

**IF YOU ARE A NEWLY REGISTERED PATIENT: PLEASE NOTE ONLY ACCESS TO APPOINTMENTS AND MEDICATION WILL BE GRANTED UNTIL YOUR MEDICAL RECORDS ARRIVE**

Completed forms should be handed to Reception, along with the required identification:

* One proof of identity (photographic, for example driving licence or passport); and
* One proof of address.

All documents should be valid an in date.

You will be contacted by email at the earliest opportunity, which should usually be within two weeks.

Please sign below to confirm that you understand this agreement

Signature: Date: (PTO:/)

***For Practice Use Only***

|  |  |
| --- | --- |
| Reception ActionReception Name:  | **Tick (✓)** |
| 1. ID CHECK – Select from the options detailed below
 |  |
| * I have seen two valid forms of identification, at least one of which is photographic and includes confirmation of address.

ID seen: |  |
| * I know this patient well and can vouch for their identity.
 |  |
| * The patient does not have any valid ID at all. Information contained within the medical record confirmed.
 |  |
| 1. Form Completion Checked.
 |  |
|  |  |
| Clinician ActionClinician Name: | **Tick (✓)** |
| 1. I confirm that record has been reviewed and access requested approved.
 |  |
| 1. Level of access enabled:
 |  |
| * Request repeat medications
 |  |
| * Booking Appointments
 |  |
| * Full Medical Record from date of clinical review
 |  |
| * Questionnaires
 |  |
| 1. Access requested declined.

Reasons: |  |
|  |  |
| Online Services Administrator ActionOnline Services Administrator Name: |  |
| 1. Patient demographic information checked against record held.
 |  |
| 1. Account created and approved access allocated.
 |  |
| 1. Patient record coded to advise patient has access to online services.
 |  |
| 1. Email sent to advise of the following:
 |  |
| * Registration details
 |  |
| * Advise request declined and reasons.
 |  |

***When processed please send form to Scanning Department to be scanned to the patient record.***