

River Lodge Surgery
Malling Street
Lewes
East Sussex
BN7 2RD

Tel: 01273 472233
Fax: 01273 486879



Anchor Field Surgery
30 Anchor Field
Ringmer
East Sussex
BN8 5QN

Tel: 01273 812338
Fax: 01273 812384

www.riverlodge-ringmersurgeries.co.uk

Online Access Registration Form

PLEASE SUPPLY 2 FORMS OF IDENTIFICATION - 1 PHOTO AND 1 WITH YOUR CURRENT ADDRESS

I would like to apply for the following online services:

| | |
|--|--------------------------|
| Requesting repeat prescriptions | <input type="checkbox"/> |
| Booking appointments | <input type="checkbox"/> |
| Viewing summary information from medical records | <input type="checkbox"/> |

In signing this registration form, I agree that (please tick):

| | |
|--|--------------------------|
| 1. I have understood the information leaflet provided by the Practice | <input type="checkbox"/> |
| 2. I consent to receiving SMS from the Practice | <input type="checkbox"/> |
| 3. I consent to receiving Emails from the Practice | <input type="checkbox"/> |
| 4. I will be required to provide photographic identification before I can access online services (e.g. driving licence, passport, identity card, etc) | <input type="checkbox"/> |
| 5. I will be provided with a user code that will be unique to me and that it is my responsibility to keep my username and passwords secure. If I believe these to have been shared inappropriately, I will reset them using instructions via the patient access website. | <input type="checkbox"/> |
| 6. If I choose to share my information with anyone else, this is at my own risk | <input type="checkbox"/> |
| 7. 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"/> |
| 8. If I see information in my record that is not about me, or is inaccurate, I will log out immediately and contact the practice as soon as possible | <input type="checkbox"/> |
| 9. It is my responsibility to notify the Practice of any change in my contact details | <input type="checkbox"/> |
| 10. Online services are provided at the discretion of the practice and may be withdrawn by the practice at any time. I understand that the practice reserves the right to withdraw my access to online services if I misuse this service | <input type="checkbox"/> |

If you would like access to your detailed coded records please request this via the SystmOne site when you have logged on.

| | | | |
|-----------|--|---------------|--|
| Full name | | Date of Birth | |
| Address | | Home Tel | |
| | | Mobile No | |
| Postcode | | Email address | |
| Signature | | Date | |

*If the patient is under the age of 16, online access may be applied for by the parent / guardian (**Proxy Access**) all patients attaining the age of 16 will be required to apply for access for online services to be continued.*

| | | |
|---|--|-------|
| Name & Signature of parent / guardian: | | Date: |
|---|--|-------|

For practice use only:

| | | | |
|---|---|-------------------|-------|
| Identity verified through (tick all that apply) | Vouching <input type="checkbox"/> Vouching with information in record <input type="checkbox"/> Photo ID <input type="checkbox"/> Proof of residence <input type="checkbox"/> | Name of verifier: | Date: |
| Name of GP authorising | | | Date: |
| Date account created / passphrase sent | | | |