**Patient Access registration**

**Name: …………………………………………………………………. Date of Birth: ………………………………….**

**Address: …………………………………………………………………………………………………………………………**

**Email Address: ……………………………………………………………………………………………………………….**

**By signing this document, you confirm that you are happy to be registered for Patient Access. Patient Access allows you to book appointments, request repeat prescriptions and view your prospective medical records from 1st of November 2022. You acknowledge that you are responsible for the security of the information that you see or download. You agree that if you choose to share your record with anyone else it is at your own risk.**

**Signature: ………………………………………………………. Date: …………………………………………………**

**If you are completing this form on a behalf of a child aged under 16, please ensure you complete THEIR details above and YOUR details in the below section.**

**Your name: ……………………………………………….. Relationship to patient: ………………………….**

**Email address: ……………………………………………………………………………………………………………..**

**For office use only: Id confirmed Passport/Driving License /Utility Bill**

 **Photo ID and Proof of Address Required – 2 Types**