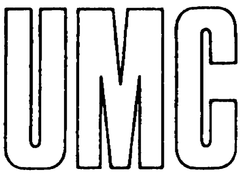

UNSWORTH MEDICAL CENTRE • PARR LANE • BURY • BL9 8JR

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Application for Vision Online Services including:

Surname:	Date Of Birth:
First Name:	
Address: Postcode:	
Email address:	
Telephone number	Mobile number

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

1. Booking / cancelling appointments	☐
2. Requesting repeat prescriptions	☐
3. Accessing my medical record	☐

I wish to access my medical record online and understand and agree with each statement (tick)

1. I will be responsible for the security of the information that I see or download	☐
2. If I choose to share my information with anyone else, this is at my own risk	☐
3. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	☐
4. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible	☐

Signature	Date

For practice use only (Please complete & tick)

Patient NHS number :		
Identity verified by (initials)	Date	Method Vouching ☐ Vouching with information in record ☐ Photo ID and proof of residence ☐
Date account created:		
Date Registration form sent : ___/___/___	By ☐ Post	By Email ☐ Given @ Reception ☐