Longfield Medical Centre

systmonline
BOOK REQUEST REGISTER

SystmOnline Application for online access

Surname	Date of Birth
First Name	
Address: Post Code:	
Email address	
Telephone No	Mobile No

I understand and agree with each statement below (please tick)

1. I will be responsible for the security of my username and password	❑
2. I will be responsible for the security of the information that I view online	❑
3. If I choose to share my information with anyone else, this is at my own risk	❑
4. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my prior agreement	❑
5. If I see information within my record that is not about me or that is incorrect, I will notify the practice as soon as possible	❑

Patient Signature	Date

For practice use only

Patient NHS Number

Method of photo ID seen	Passport ❑ Driving Licence ❑ Other (please state)	Identity verified by (initials)
Date user ID / password printed & Issued	Authorised by	

Notes

If you believe any information within your record may be incorrect, or you would like its visibility removed, please inform Reception as soon as possible.