

# The Mill Practice

## Application for Online Access

Surname	Date of birth
First name	
Address	
Postcode	
Preferred Email address (not shared):	
Mobile number	Home number

I wish to have access to online services

I give consent for The Mill Practice to contact me via mobile text message and email

**I understand that by signing this form I agree with the following:**

I have understood the information provided by the practice.

I will be responsible for the security of the information that I see or download.

If I choose to share my information with anyone else, this is at my own risk.

I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement.

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
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**For practice use only**

Patient CHI number			
Identity verified by (initials)	Date	Method	
		Photo ID	<input type="checkbox"/>
		Proof of residence	<input type="checkbox"/>
		Vouching	<input type="checkbox"/>
		Other	<input type="checkbox"/>
<u>Authorised by</u>			Date
Date account created			
Date registration letter/email sent			