Dr A Hayat & Partners
Maybush Medical Centre

NHS
Providing NHS services

Application for Patient Online Services – FORM A

This form is used only for patients over the age of 16 having access to their own records. Please ask reception for FORM B if this doesn't apply.

Full Name:	
Date of Birth:	
Current Address:	
Postcode	
Mobile Number:	
Email Address:	
Nominated Pharmacy:	

☐ I am **over the age of 16** and requesting access to patient online services

PROOF OF IDENTITY

In order to protect others from accessing your records without your authorisation/consent, we need to ask you to prove your identity, unless you are known to the staff member in which case we can vouch for your identity.

DECLARATION

The information which I have supplied in this application is correct, and I am the patient to whom the information relates to.

Signature of Patient:	Date:

PRACTICE USE ONLY

☐ Patient is aged 16 or over

☐ Access granted

☐ Patient ID verified

☐ Patient advised of username/password