Vision Online - Patient registration form

If you would like to register for this online service please complete the form below and return it to your practice in person, **along with a valid form of identification, for example photo ID or your passport.**

If you are applying for Proxy Access for someone who is aged 12 years or over, patient consent or sight of relevant official documentation will be required (e.g. Power of Attorney).

Once you are registered the practice will give you the information that will enable you to create a username and password.

Patient details	**Please complete in BLOCK CAPITALS**
Patient forename	
Patient surname	
Date of birth	D D / M M / Y Y Y Y
Email address **This email address will be used by your practice to send you notifications and reminders.**	
Mobile number	
Signature	
Date	D D / M M / Y Y Y Y

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

1. I have read and understood the information leaflet provided by the practice	☐
2. I will be responsible for the security of the information that I see or download	☐
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 agreement	☐
5. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible	☐

Completing the form on behalf of the patient?	
Print forename	
Print surname	
Relationship to patient	
Signature	
Date	D D / M M / Y Y Y Y

Staff use only	
Patient ID seen	
Type of ID	
Staff name	
Date	D D / M M / Y Y Y Y