**Manor Primary Care - Application for Repeat Prescriptions**

Surname………………………………………First Name(s)……………………………..

Address………………………………………………………………………………………

……………………………………………..................Post Code…………………………

Date of Birth ……………………………

Email Address ……………………………………………………………………….

Telephone Number …………………… Mobile Tel No. …………………………………

I wish to have access to Patient Access in order to request Repeat Prescriptions. I understand and agree with all the statements below:

|  |
| --- |
| 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. If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible |
| 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 |
| 5. If I think that I may come under pressure to give access to someone else unwillingly I will contact the practice as soon as possible.  |

|  |  |
| --- | --- |
| Signature……………………………………………………… | Date ………………………. |

For practice use only

|  |  |
| --- | --- |
| Patient NHS No. | EMIS No. |
| ID Verified by (initials)  | Date | **Enter type of ID checked eg driving licence**Photo ID…………………………….……Address ID ………………………………Vouching only…………………………. |
| Date Account Created ……………………………….. In Registration/Edit Pt/Patient Services create account linkage/print | By Whom …………………………………………... |
| **Signature by Patient** |
| **I confirm receipt of my PIN in order to create my Patient Access Account to order repeat medication:****……………………………………………………………….(Patient Signature)****(It is strongly recommended that you do not share your PIN with any pharmacies or other third parties** |

**This form is to be retained by Manor Primary Care**