ST RICHARDS ROAD SURGERY

TEXT/EMAIL/MESSAGING AND VIDEO CONSULTATION REGISTRATION FORM

Surname:	
Forename:	
Date of birth:	
Address:	
Postcode:	
Email address:	
Telephone –home:	
Telephone – mobile:	

I wish to register for the following consultation, messaging and reminder services: (please tick all required)

Text/SMS Appointment Reminder Service	
Communication via email	
Communication via text message/SMS	
Communication via telephone answer machine	
Video consultations	

Applicants are required to tick all statements below:

I have read and understand the information leaflet provided by the practice.	
I will be responsible for the information sent to me.	
If I choose to share the information sent 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 receive information that does not relate to me, or is inaccurate I will contact the practice as soon as possible.	

Signature:		**Date:**	