indici

myindici Patient Portal

REGISTRATION & CONSENT FORM (ADULT PATIENT WITH CAPACITY)

Family name	
First name	
NHI	
Date of birth	
Address	
Email Address	
Telephone Number	
Mobile Number	

I confirm that I wish to request access to the following online services provided by Healthspace (please tick as appropriate):	
1. Accessing my medical record (including details of medications / test results) as made available by the Practice.	☐
2. Secure messaging with the Practice	☐
3. Making an Appointment	☐
4. Requesting Repeat Prescriptions	☐
5. Participating in video consultation	☐
6. Account payment	☐
7. Accessing online resources	☐
Please note that the online services made available to you by our Practice may vary from time to time and that past use by you of an online service and/or feature does not mean that it will continue to be available in the future.	

In requesting access to the above services, I confirm that I understand and agree as follows (please tick all):	
1. I have read and understood the information leaflet provided by the Practice.	☐
2. I have read, understood and agree with the Patient Portal User Agreement on www.myindici.co.nz/termsandconditions.	☐
3. I understand that if I share information with anyone else that I do so at my own risk.	☐

4. I will contact the Practice immediately if I suspect that my account has been accessed by someone without my consent.	☐
5. If I see information in my account that does not relate to me, or is inaccurate or incorrect, I will log out of my account immediately and contact the Practice as soon as possible.	☐
6. I will be responsible for the security of the information that I view or download.	☐

Registration Preferences (please tick)	
I wish to collect my registration details in person (with proof of identity)	☐
I would like my registration details to be sent to me by post at the above address	☐
I would like to receive information about services / products by:	
Email	☐
SMS	☐
Phone	☐
Fax	☐
Post	☐

Signature		**Date**	

FOR PRACTICE USE ONLY

Steps	Information / Documents		Comments
Identity Verified (tick where appropriate)	Photo ID	☐	
	Proof of residence	☐	
	Other*	☐	
Name of Verifier			
Date of Verification			
Authorised by (if applicable)			
Date account created			
Date registration details sent			
Scanned to patient record			