cid:image001.png@01CF9862.86871390**Application for Proxy Access to Online Services**

To apply for proxy access to online services from the practice the patient and their proxy should complete this form and present it to the receptionist or email it to [admin.staffahealth@nhs.net](mailto:admin.staffahealth@nhs.net). It should be **accompanied by two forms of ID for each person** one which has a photograph and another that has proof of your addresses. A photograph of your ID sent by email is acceptable. **Parents/guardians** applying for access for children under 11 years **must also provide proof of parental responsibility**.

To obtain proxy access, both the patient and the representative must be registered for online access at our practice through the SystmOnline service.

**Section 1 - Patient’s details** (this is the person whose records are being accessed)

|  |  |  |
| --- | --- | --- |
| First name: | | Surname: |
| Date of birth: | Email address: | |
| Home Telephone number: | | Mobile telephone number: |
| Address:  Postcode: | |  |

Is the patient under the age of 11 years?

Yes  If yes please go straight to Section 2.

No 

If No please give details of the reason why proxy access is requested:

………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

If the patient is aged over 11 years consent for access must be given by the patient. If consent cannot be given please explain why above and go to section 2.

Patient Consent for access to medical record:

I,…………………………………………………...…….. (name of patient), give permission to my GP practice to give the following person/people………………………………………………………. ………………………………...proxy access to the online services as indicated below in section 2.

I reserve the right to reverse any decision I make in granting proxy access at any time.

I understand the risks of allowing someone else to have access to my health records.

I have read and understand the information leaflet provided by the practice

|  |  |
| --- | --- |
| Signature of patient: | Date: |

**Section 2 - The Representatives**

(These are the people to be granted proxy access to the patient’s online records, appointments or repeat medications.)

|  |  |
| --- | --- |
| Surname | Surname |
| First name | First name |
| Date of birth | Date of birth |
| Address  Postcode | Address (tick if both same address 🞏)  Postcode |
| Email | Email |
| Telephone | Telephone |
| Mobile | Mobile |
| Relationship to patient: | Relationship to patient: |

**Section 3 - Access to be granted**

Please tick the types of access to be granted to the person(s) in section 2 above

|  |  |
| --- | --- |
| 1. Booking appointments |  |
| 2. Requesting repeat medications |  |
| 3. Viewing medical record |  |

**Section 4 – Declaration by representative(s):**

I/we understand my/our responsibility for safeguarding sensitive medical information and I/we understand and agree with each of the following statements:

|  |  |
| --- | --- |
| 1. I/we have read and understood the information leaflet provided by the practice and agree that I will treat the patient information as confidential | 🞏 |
| 1. I/we will be responsible for the security of the information that I/we see or download | 🞏 |
| 1. I/we will contact the practice as soon as possible if I/we suspect that the account has been accessed by someone without my/our/the patients agreement | 🞏 |
| 1. If I/we see information in the record that is not about the patient, or is inaccurate, I/we will contact the practice as soon as possible. I will treat any information which is not about the patient as being strictly confidential | 🞏 |

|  |  |
| --- | --- |
| Signature/s of representative/s: | Date/s: |

**For practice use only**

|  |  |  |  |
| --- | --- | --- | --- |
| Patient NHS number: | |  | |
| Identity verified by: (Name) | Date: | | |
| Were both the patient and the proxy/proxies present for the identity check? Yes  No   Confirm identity that has been checked (tick):  Photo ID and proof of residence for the Representatives   Photo ID and proof of residence for the Patient   Proof of Parental responsibility (for all patients under 11 years)   Other ID for Proxy/proxies (include details below)   Other ID for Patient   Vouching for Patient   Vouching for Proxy   State type of ID documents checked: | | | |
| **For all Proxy access please pass this form to the nominated administrators.** | | | |
| Access in SystmOne authorised by (name): | | | Date: |
| Date account created: | Date PIN/letter sent/given: | | |
| Level of record access enabled:  All Access Declined   Booking appointments   Requesting repeat medications   Detailed Coded Records Access   Full Prospective Medical Record access  | Notes / explanation: | | |