**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 ddicb.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**.

**PLEASE NOTE: Both the patient and the proxy/representative must be registered at Staffa Health to set up proxy access.**

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

|  |
| --- |
| First name: |
| Surname: |
| Date of birth: |
| Email address (essential to access online services): |
| 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.

**Section 2 - The Representative**

(This is the person to be granted proxy access to the patient’s online records, appointments or repeat medications.)

|  |
| --- |
| First name: |
| Surname: |
| Date of birth: |
| Email address (essential to access online services): |
| Home Telephone number: |
| Mobile telephone number: |
| Address:Postcode: |
| Relationship to patient:  |

**Section 3 – Level of access to be granted to the person above**

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

|  |  |
| --- | --- |
| 1. Booking appointments |  |
| 2. Requesting repeat medications |  |
| 3. Coded information only (not the full record |  |
| 4. Viewing the full medical record (includes consultations, documents and test results |  |

**Section 4 - Patient's 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 in section 2.

* I understand that I reserve the right to reverse any decision I make in granting proxy access at any time and will contact the practice if I wish to do this
* 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 5 – Declaration by representative:**

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

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

|  |  |
| --- | --- |
| Name of representative: |  |
| Signature of representative: |  |
| Date: |  |

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**For practice use only**

|  |
| --- |
| **Patient NHS number:** |
| **Identity verified by (name):**  |   |
| **Date verified:**  |  |

**Patients' identity check**

|  |
| --- |
| **Method of checking identity:**  |
| Photo ID and proof of residence  | State type of ID documents checked**:** ***PLEASE NOTE 2 FORMS OF ID ARE REQUIRED, ONE WITH A PHOTOGRAPH AND ANOTHER WITH THE CORRECT ADDRESS. IF THIS CANNOT BE PROVIDED PLASE USE INFORMATION FROM THE RECORD TO CONFIRM IDENTIFY*** |
| If cannot provide documents above use conformation of information from medical record (vouching) | Include details of questions asked:  |

**Representatives' identity check:**

|  |
| --- |
| **Method of checking identity:**  |
| Photo ID and proof of residence  | State type of ID documents checked**:** ***PLEASE NOTE 2 FORMS OF ID ARE REQUIRED, ONE WITH A PHOTOGRAPH AND ANOTHER WITH THE CORRECT ADDRESS. IF THIS CANNOT BE PROVIDED PLASE USE INFORMATION FROM THE RECORD TO CONFIRM IDENTIFY*** |
| If cannot provide documents above use conformation of information from medical record (vouching)  | Include details of questions asked:  |
| Proof of parental responsibility checked for all children under 16 years (if appropriate) |  |

|  |  |
| --- | --- |
| Access in SystmOne authorised by (name): |  |
| Date account created: |  |
| Date access granted from (should always be todays date) |  |
| Level of record access enabled (tick): | Granted | Declined |
| Booking appointments  |  |  |
| Requesting repeat medications  |  |  |
| Detailed Coded Records Access  |  |  |
| Full Prospective Medical Record access  |  |  |
| Was any retrospective access granted? please state. |  |
|   Notes / explanation: |