Dickens Place Surgery

systmonline BOOK REQUEST REGISTER

Consent to proxy access to GP online services

Note: If the patient does not have capacity to consent to grant proxy access and proxy access is considered by the practice to be in the patient's best interest section 1 of this form may be omitted.

Section 1

I,…….. (name of patient), give permission to my GP practice to give the named person below 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

1. Online appointments booking	☐
2. Online prescription management	☐
3. Accessing the medical record for	☐

Section 3

I…….. (name of representative) wish to have online access to the services ticked in the box above in section 2

for ……..…… (name of patient).

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	☐
2. I will be responsible for the security of the information that I/we see or download	☐
3. I will contact the practice as soon as possible if I suspect that the account has been accessed by someone without my/our agreement	☐
4. 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	☐

Signature of representative	Date

The patient

(This is the person whose records are being accessed)

Surname	Date of birth
First name	
Address Postcode	
Email address	
Telephone number	Mobile number

The representative

(This are the people seeking proxy access to the patient's online records, appointments or repeat prescription.)

Surname
First name
Date of birth
Address Postcode
Email
Telephone
Mobile

For practice use only

The patient's NHS number		The patient's practice computer ID number
Identity verified by (initials)	Date	Method of verification Vouching ☐ Vouching with information in record ☐ Photo ID and proof of residence ☐
Proxy access authorised by		Date
Date account created		
Notes / comments on proxy access		