Consent to proxy access for SystmOnline

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. Proxy access application will not be accepted from any third party commercial company i.e. Insurance company or solicitors.

Proxy Access: Parents may request a proxy access to their children's records; this will cease automatically when the child reaches the age of **14**. Any subsequent proxy access will need to be authorised by the patient subject to a Gillick competency test being completed.

The patient (This is the person whose records are being accessed)

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

Section 1

I, ……..…., give permission to my GP practice to give the following people proxy access to my online services as indicated below in section 2:

Name of 1st Representative:
Name of 2nd Representative (if any):

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

Please sign under each service you are granting proxy access for – you can choose which of these services your representative can access

1. Online appointments booking	☐
2. Online prescription management	☐
3. Summary Care Record (recent medication and allergies)	☐
4. Full medical records	☐

The representatives

(These are the people seeking proxy access to the patient's online records, appointments or repeat prescriptions)

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

Section 3

I/we, the representative/s named above in section 1, wish to have online access to the services ticked in the box above in section 2 for the patient.

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	☐
2. I/we will be responsible for the security of the information that I/we see or download	☐
3. 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 agreement	☐
4. 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

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For practice use only

The patient's NHS number		Notes / comments on proxy access
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