Nettleham Medical Practice

14 Lodge Lane, Nettleham, Lincoln, LN2 2RS
Tel: 01522 751717
www.nettlehammedical.co.uk

Consent to proxy access to GP online services

Section 1 | to be completed by the patient
(this is the person whose records are being accessed)

The patient

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

1.	I give permission to my GP practice to give the representatives named in section 2 proxy access to the following services:	
	Requesting repeat prescriptions	☐
	Accessing my full medical record – **from specified date…….** **Note:** this must be on or after the date that you registered with Nettleham Medical Practice **Note:** this will be verified by a GP and can take up to 28 days	☐
2.	I understand that I reserve the right to reverse any decision I make in granting proxy access at any time.	☐
3.	I understand the risks of allowing someone else to have access to my health records.	☐
4.	I have read and understand the information leaflet provided by the practice.	☐

Signature of patient	Date

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 2 | to be completed by the representative/s
(these are the people seeking proxy access to the patient's online service)

The representatives

Surname	Surname
First name	First name
Date of birth	Date of birth
Address Postcode	Address Postcode
Email	Email
Telephone number	Telephone number
Mobile number	Mobile number
Relation to patient	Relation to patient

1.	I/we wish to have online access to the services ticked in the box above in section 1 for the patient named.	☐
2.	I/we understand my/our responsibility for safeguarding sensitive medical information and I/we understand and agree with each of the following statements:	☐
	I/we have read and understood the information leaflet provided by the practice and agree that I will treat the patient information as confidential.	☐
	I/we will be responsible for the security of the information that I/we see or download	☐
	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.	☐
	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

Section 3 | to be completed by the practice

Patient NHS number	
Patient identity verified by (initials)	**Method** Vouching ☐ Vouching with information in record ☐ Already user of SystmOnline ☐ Photo ID ☐
Representatives identity verified by (initials)	**Method** Vouching ☐ Vouching with information in record ☐ Is a registered patient and user of SystmOnline ☐ Photo ID ☐
Account created by (initials)	Date

If patient does not have capacity to grant proxy access, complete the below:

1. Parental responsibility ☐	By staff member (initials)
2. Court order verified ☐	
3. Power of attorney verified ☐	
4. Patients best interest ☐	

Pass form to Deputy Practice Manager if patient wishes to view full medical record form from the date they registered with the practice.

Notes checked by clinician (initials)	Authorised ☐ Declined ☐
Access enabled by (initials)	Date