**Nettleham Medical Practice**

**14 Lodge Lane, Nettleham, Lincoln, LN2 2RS**

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[**www.nettlehammedical.co.uk**](http://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) |
| 1. Court order verified |
| 1. Power of attorney verified |
| 1. 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 |