

**Application for Patient Access Online (Proxy)**

|  |
| --- |
| **Patient Details – the person whose records are being accessed** |
| Surname: | Date of Birth: |
| First Name (s): |
| Address: |
| Telephone Number: | Mobile Number: |

I wish my proxy to have access to ‘SystmOnline’ for the following services: -

|  |  |
| --- | --- |
| * Booking Appointments (available within 48 hours)
 | o |
| * Requesting repeat medications (available within 3 working days)
 | o |
| * Accessing summary of my medical records and detailed coded entries
 | o |
| * View pathology results available
 | o |
| ***I reserve the right to reverse any decision I make in granting proxy at any time, I understand the risks of allowing someone else to have access to my medical records.*** |
| Signature of Patient: ……………………………………………………. Date: ………………………. |

|  |
| --- |
| **Representative’s details – the person seeking proxy access to the above patients online services** |
| Surname: | Date of Birth: |
| First Name (s): |
| Address: |
| Telephone Number: | Mobile Number: |
| Relationship to patient: |

|  |  |
| --- | --- |
| * I understand my responsibility for safeguarding sensitive medical information
 | o |
| * I have read and understood the patient Guidance notes for SystmOnline and User Policy
 | o |
| * I will be responsible for the security of the information that is seen or downloaded
 | o |
| * I will contact the practice as soon as possible if I suspect that the account has been accessed by someone without the agreement of the patient
 | o |
| * 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.
 | o |
| * I understand that the practice may not be able to offer me these services due to any reasons such as concern that the information could cause harm to the patient’s physical / mental health or where there is reference to third parties.
 | o |
| * I understand the practice has the right to remove online access for anyone that doesn’t use this service responsibly
 | o |
| Signature of Proxy: …………………………………………………………… Date: ……………………………. |

**FOR PRACTICE USE ONLY**

|  |  |
| --- | --- |
| Patient NHS Number | Identity Verified by Date: |
| Method of verification | Vouching  |  o |
| Vouching with information in record  |  o |
| Photo ID and proof of address  |  o |
| Other (Please state) …………………………………………………… |  o |
| Authorised and completed date and sign |  |
| Level of access enabled | Booking appointments Prescription Requests  |  o o   |
| Practice Coms Demographics  |  o  o |
| Allergies Immunisations  |  o o |
| Detailed Coded Record Access  |  o |