

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

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| **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: -

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| * 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: ………………………. | |

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| **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: | |

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| * 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**

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| 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 |