Fremington Medical Centre

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Barnstaple
EX31 2PG

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www.fremingtonmedicalcentre.co.uk

Proxy Online Services Application Form

Before completing this form, the following is required:

- You must also be registered at this practice
- You must also have your own online services access at this practice (SystmOnline)

Note: If the patient does not have capacity to consent to grant proxy online access, section 4 of this form can be skipped.

Section 1 - Patient's Details *(This is the person whose records are being accessed)*

Full Name:			**Date of Birth:**	
Address:				
			Post Code:	
Home Telephone:		☐	Please tick **one** box to indicate your preferred contact number	
Mobile Telephone:		☐		
Email Address:				

Section 2 - Representative's Details *(This is the person seeking proxy online access)*

Full Name:			**Date of Birth:**	
Address:				
			Post Code:	
Home Telephone:		☐	Please tick **one** box to indicate your preferred contact number	
Mobile Telephone:		☐		
Email Address:				

Relationship to Patient:	☐ Mother ☐ Father ☐ Son ☐ Daughter ☐ Other (please specify):

Section 3 - Services Requested

I wish to have access to the following online services (tick all that apply):	
• Booking appointments	☐
• Requesting repeat prescriptions	☐
• Accessing my medical record - Summary Record Access **(Age 16+)**	☐
• Accessing my medical record - Full Record Access **(Age 16+)**	☐

Section 4 - Consent (Patient)

I, ________________________________ (name of patient), give permission to Fremington Medical Centre to give the following person ________________________________ (name of representative), proxy access to the online services as indicated above in section 3.

Signature (Patient):		**Date:**	

Section 5 - Consent (Representative)

I, ________________________________ (name of representative) wish to have online access to the services ticked in the box above in section 3 for ________________________________ (name of patient).

I understand my responsibility for safeguarding sensitive medical information and I understand and agree with each of the following statements (tick):

Statement	Tick
• I will be responsible for the security of the information that I see or download	☐
• If I choose to share any information with anyone else, this is at my own risk	☐
• If I suspect that the account has been accessed by someone without my agreement, I will contact the practice as soon as possible	☐
• 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	☐
• If I think that I may come under pressure to give access to someone else unwillingly I will contact the practice as soon as possible.	☐

Signature (Representative):		**Date:**	

Upon completion of this form, please ensure that handwritten signatures have been provided where necessary; then return the form to the surgery along with some ID for the patient (to view what we accept, please visit the Online Services page on our website).

Thank you.

FOR PRACTICE USE ONLY	
Patient's NHS Number:	ID Verified By (Initials):
Date:	Method: Vouching ☐ Vouching with information in record ☐ ID and/or proof of residence ☐
Access Granted: Appointment booking ☐ Repeat prescription ordering ☐ Summary record access ☐ Full record access ☐	Comments:
Access End Date Set: Yes ☐ No ☐	Access End Date: