



Proxy Online Services Application Form

Before completing this form, please read the following:

- The patient must already have their own online services account at this practice (SystemOnline)
- ID will be required from the patient before we can grant proxy online access

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:		<input type="checkbox"/>	Please tick one box to indicate your preferred contact number	
Mobile Telephone:		<input type="checkbox"/>		
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:		<input type="checkbox"/>	Please tick one box to indicate your preferred contact number	
Mobile Telephone:		<input type="checkbox"/>		
Email Address:				

Relationship to Patient:	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other (please specify):
--------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

Section 3 - Services Requested

I wish to have access to the following online services (tick all that apply):	
• Booking appointments	<input type="checkbox"/>
• Requesting repeat prescriptions	<input type="checkbox"/>
• Accessing my medical record - Summary Record Access (Age 16+)	<input type="checkbox"/>
• Accessing my medical record - Full Record Access (Age 16+)	<input type="checkbox"/>

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):

• I will be responsible for the security of the information that I see or download	<input type="checkbox"/>
• If I choose to share any information with anyone else, this is at my own risk	<input type="checkbox"/>
• If I suspect that the account has been accessed by someone without my agreement, I will contact the practice as soon as possible	<input type="checkbox"/>
• 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	<input type="checkbox"/>
• 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.	<input type="checkbox"/>

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: <div style="text-align: right;"> Vouching <input type="checkbox"/> Vouching with information in record <input type="checkbox"/> ID and/or proof of residence <input type="checkbox"/> </div>
Access Granted: <div style="text-align: right;"> Appointment booking <input type="checkbox"/> Repeat prescription ordering <input type="checkbox"/> Summary record access (Age 16+) <input type="checkbox"/> Full record access (Age 16+) <input type="checkbox"/> </div>	Comments:
Access End Date Set: <div style="text-align: right;"> Yes <input type="checkbox"/> No <input type="checkbox"/> </div>	Access End Date: