Fremington Medical Centre

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Proxy Online Services Application Form

Before completing this form, please read the following:

- The representative must already have their own online services account (SystmOnline)
- ID will be required from the patient and the representative 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:		☐	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):

• 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 both the patient and the representative.

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 (Age 16+) ☐ Full record access (Age 16+) ☐	Comments:
Access End Date Set: Yes ☐ No ☐	Access End Date: