Longfield Medical Centre

systmonline
BOOK REQUEST REGISTER

Consent to proxy access to GP online services

Note: If the patient does not have capacity to consent to grant proxy access and proxy access is considered by the practice to be in the patient's best interest section 1 of this form may be omitted.

Section 1

I …….…….. (name of patient), give permission to my GP practice to give the named person in Section 3 below proxy access to the online services as indicated below in section 2.

- I reserve the right to reverse any decision I make in granting proxy access at any time.
- I understand the risks of allowing someone else to have access to my health records.
- I have read and understand the information within this form.

Patient Signature:	
Date:	

Section 2

Please tick all that apply:

1. Online appointments booking	☐
2. Online prescription management	☐

Section 3

I……. (name of the representative) wish to have online access to the services ticked in the box above in section 2 for …… (name of patient). I understand my responsibility for safeguarding sensitive medical information and I understand and agree with each of the following statements:

1. I have read and understood the information leaflet provided by the practice and agree that I will treat the patient information as confidential	☐
2. I will be responsible for the security of the information that I/we see or download	☐
3. I will contact the practice as soon as possible if I suspect that the account has been accessed by someone without my/our agreement	☐
4. 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	☐

Signature of Representative:	
Date:	

The patient

(This is the person whose records are being accessed)

Title (please tick one):	Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other:
Forename(s):	
Surname:	
Date of Birth:	
Current Address: (including postcode)	
Telephone/Mobile No:	
Email:	

The representative

(This is the person seeking proxy access to the patient's online records, appointments or repeat prescription.)

Please tick if you are you a patient at Longfield Medical Centre.	☐

Title (please tick one):	Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other:
Forename(s):	
Surname:	
Date of Birth:	
Current Address: (including postcode)	
Telephone/Mobile No:	
Email:	
Relationship to Patient:	

For practice use only

Date:…..…….. ID Checked By: …….

Patients ID seen & Type: ☐ …….....

Representatives ID seen & Type: ☐ ……..…….

Date account created	
Notes or comments on proxy access:	