

Application for patient online services Churchmere Medical Group

ONLINE ACCESS TO HEALTH RECORDS REQUEST – PROXY ACCESS - PRESCRIPTIONS ONLY

Proxy Online access will **only** be granted for patients between the ages of 13 and 17 years of age if the patient is deemed not to have capacity or there are exceptional circumstances i.e for medical reasons. If this is the case, then a GP will review the records, and this may require a discussion. Access will need to be reviewed on a regular basis.

If a GP or other health professional suspects that a patient is being coerced to give proxy access, they will attempt to establish the true position with the patient. If after discussion with the patient, there are still grounds for suspicion that the patient is not giving access freely, then the GP will not authorise proxy access.

Section 1: Patient details

Surname		Former name	
Forename		Title	
Date of birth		Address:	
Telephone number		Postcode:	
Mobile number			
NHS number (if known)		Hospital number (if known)	
Email Address			

Section 2: Consent to proxy access to GP Online Services (if patient has capacity)

- I (name of patient), give permission to my GP practice to give the following person/people..... proxy access to the online services as indicated below in Section 5
- 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 leaflet provided by the organisation

Patient signature		Date	
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I/We wish to have access to the health records on **behalf of** the above-named patient

Surname		Surname	
First name		First name	
Date of birth		Date of birth	
Address		Address	
Postcode		Postcode	
Email		Email	
Telephone		Telephone	
Mobile		Mobile	

(If more than one person is to be given access then please list the above details for each additional person on a separate sheet of paper)

Reason for access:

I have been asked to act by the patient	☐
I have full parental responsibility for the patient and the patient is under the age of 18 and has consented to my making this request or is incapable of understanding the request (delete as appropriate)	☐

Section 4: Consent to proxy access to GP Online Services (if patient does not have capacity)

I/We wish to have access to the health records on **behalf of** the above-named patient

Surname		Surname	
First name		First name	
Date of birth		Date of birth	
Address		Address	
Postcode		Postcode	
Email		Email	
Telephone		Telephone	
Mobile		Mobile	

(If more than one person is to be given access then please list the above details for each additional person on a separate sheet of paper).

Reason for access:

I/We have been appointed by the Court to manage the patient's affairs and attach a certified copy of the court order appointing me to do so	☐
I am/We are acting <i>in loco parentis</i> and the patient is incapable of understanding the request	☐
I am/We are the deceased person's personal representative and attach confirmation of my/our appointment (grant of probate/letters of administration)	☐
I/We have written and witnessed consent from the deceased person's personal representative and attach Proof of Appointment	☐
I/We have a claim arising from the person's death (please state details below)	☐

Section 5: Proxy access online services available

I/We wish to have access to the following online services (please tick all that apply):

Requesting repeat prescriptions	☐
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Section 6: Proxy declaration

I/We wish to access to the medical record online of the above patient and I/we understand and agree with each statement (tick)

I/We have read and understood the information leaflet provided by the organisation and agree that I/we will treat the patient information as confidential	☐
I/We will be responsible for the security of the information that I/we see or download	☐
I/We will contact the practice as soon as possible if I/we suspect that the account has been accessed by someone without my/our agreement	☐
If I/we see information in the record that is not about the patient or is inaccurate, I/we will contact the organisation as soon as possible. I/we will treat any information which is not about the patient as being strictly confidential	☐

I declare that the information given by me is correct to the best of my knowledge and that I am entitled to apply for access to the health records referred to above under the terms of the [Data Protection Act 2018](#).

You are advised that the making of false or misleading statements in order to obtain personal information to which you are not entitled is a criminal offence which could lead to prosecution.

Applicant signature		Date	
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Section 7: Proof of identity

Under the Data Protection Act 2018, you do not have to give a reason for applying for access to your own health records. However, all applicants will be asked to provide two forms of identification, one of which must be photographic identification before access can be set up.

Please speak to reception if you are unable to provide this.

ADDITIONAL NOTES:

Before returning this form, please ensure that you have:

- Signed and dated the form
- Are able to provide proof of your identity or alternatively confirmed your identity by a countersignature
- Enclosed documentation to support your request (if applicable)

Incomplete applications will be returned; therefore, please ensure you have the correct documentation before returning the for

For office use only:

Identification verification must be verified through two forms of ID

- One must contain a photo (e.g., passport or photo driving licence) and bank statement
- When this is not available, vouching by a member of staff or by confirmation of information in the records by one of the management team or a partner may be used

RECEPTION TO COMPLETE				
Request received		Request refused		
		Request completed		
Comments				
Identification of	☐ Child (aged 13-17)	☐ Patient	☐ Applicant	
Identity verified by: (Print Name)		Date		
NHS Number:		EMIS Number:		
Identity method	☐ Photo ID and proof of residence of Patient ☐ Photo ID and proof of residence of Proxy applicant if necessary ☐ Vouching – by whom – PRINT NAME ☐ Vouching with information in record – by whom – PRINT NAME			
	<u>ONLINE ACCESS TEAM TO COMPLETE BELOW</u>			
Proxy access authorised by				
Proxy access coded in notes	☐ Yes			
Date account created		Date password sent		
Level of access enabled	☐ All	☐ Prospective	☐ Retrospective	☐ Limited parts
Notes for proxy access (If any request is refused, discuss with the organisation's DPO before informing patient/applicant)				

SEE PATIENT CONSULTATION NOTES FOR THE ACCESS AUTHORISED		
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