**Agreement for Proxy Access to Online Services**

If you require any assistance accessing the new online service provider, please use the following web address and this will take you directly to the Guide for Patients: <https://systmonline.tpp-uk.com/2/help/help.html> .

If you have any queries please discuss them with the Practice and only complete this form when you are satisfied that you queries have been answered appropriately.

**Section 1 *(to be completed by the patient)***

|  |  |
| --- | --- |
| Name: | Date of Birth: |
| Address: | NHS Number: |
|  | Mobile Number: |
|  | Email Address: |

I *(name of patient),* give permission to St Agnes Surgery to give the following people *(name of representative/s)* proxy access to the services detailed below.

I wish for proxy access to the following services (please tick all that apply) to be provided to the named representative(s):-

|  |  |
| --- | --- |
| **Service Options** | **Tick (✓)** |
| Request Repeat Medications |  |
| Booking Appointments |  |
| Full Medical Record dated from clinical review |  |
| Questionnaires |  |

* I reserve the right to reverse any decision that 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 contained within the leaflet provided.

Signature of Patient Date

***Section 1 can be omitted if patient does not have capacity to grant proxy access.***

|  |  |
| --- | --- |
| Please tick if patient does not have capacity to consent to grant proxy access |  |

**Section 2 *(to be completed by the representative/s of the patient)***

|  |  |
| --- | --- |
| Representative 1: | Date of Birth: |
| Address: | NHS Number: |
|  | Mobile Number: |
|  | Email Address: |
|  |  |
| Representative 2: | Date of Birth: |
| Address: | NHS Number: |
|  | Mobile Number: |
|  | Email Address: |

I/We *(name/s of representative/s)* wish to have online access to the services indicated in Section 1 for

*(name of patient).* If patient does not have capacity to grant proxy access please select the services you would like access to:

|  |  |
| --- | --- |
| **Service Options** | **Tick (✓)** |
| Request Repeat Medications |  |
| Booking Appointments |  |
| Full Medical Records dated from clinical review |  |
| Questionnaires |  |

I/We understand my/our responsibility for safeguarding sensitive medical information and I/We understand and agree to each of the following statements:

|  |  |
| --- | --- |
| **I/We understand and agree with each of the following statements:-** | **Tick (✓)** |
| I/We have read and understood all of the information detailed within ‘The Waiting Room – Accessing Online Services’ leaflet and agree to keep all patient information 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 see any information within the record that is inaccurate or incorrect. |  |
| I/We agree to contact the Surgery as soon as possible if I/we suspect that the account has been accessed by a third party without my/our permission. |  |

Signature of Representative 1 Date

Signature of Representative 2 Date

Completed forms should be handed to Reception, along with the required identification:

* One proof of identity (photographic, for example driving licence or passport) for patient (if appropriate) and representative(s); and
* One proof of address patient (if appropriate) and representative(s).

All documents should be valid an in date.

You will be contacted by email at the earliest opportunity, which should usually be within two weeks.

(PTO:/)

***For Practice Use Only***

|  |  |
| --- | --- |
| Reception Action  Reception Name: | **Tick (✓)** |
| 1. ID CHECK – Select from the options detailed below |  |
| * I have seen two valid forms of identification from all parties (if appropriate), at least one of which is photographic and includes confirmation of address.   ID seen   * Representative 1: * Representative 2: * Patient: |  |
| * I know patient well and can vouch for their identity. |  |
| * The patient does not have any valid ID at all. Information contained within the medical record confirmed. |  |
| 1. Form Completion Checked. |  |
|  |  |
| Clinician Action  Clinician Name: | **Tick (✓)** |
| 1. I confirm that record has been reviewed and access requested approved. |  |
| 1. Level of access enabled: |  |
| * Request repeat medications |  |
| * Detailed Coded Records from 1.6.20 |  |
| * Questionnaires |  |
| 1. Access requested declined.   Reasons: |  |
|  |  |
| Online Services Administrator Action  Online Services Administrator Name: |  |
| 1. Patient demographic information checked against record held. |  |
| 1. Account created and approved access allocated. |  |
| 1. Patient record coded to advise representative(s) has/have proxy access to online services. |  |
| 1. Pop up added to patient record to advise that representative(s) has/have proxy access to online services. |  |
| 1. Email sent to advise of the following: |  |
| * Registration details |  |
| * Advise request declined and reasons. |  |

***When processed please send form to Scanning Department to be scanned to the patient record.***