ONLINE & PROXY ACCESS PATIENT APPLICATION FORM

Note 1: *Please print and return this form to reception as directed (key principles – section 3) and bring two IDs. Forms are available at all sites, but cannot accept without ID.*

Note2: *If the patient does not have capacity to consent to grant proxy access and proxy access is considered by MVP to be in the patient's best interest, section 1 of this form may be omitted.*

Section 1 – Patient consent

I…… (Name of patient) D.O.B……

Give permission to MVP (my named GP practice) to give the following person / people access to my medical record

……

I reserve the right to reverse (in writing) 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 Practice.

Signed……..Date……..

Section 2 – What proxy access is required?

Service	Tick
Online Appointments Booking	
Online Prescription Management	
Online Triage	
Summary Care Record*	
Detailed Coded Record**	

*Summary care Record – gives access to summary of the patient's allergies, drug sensitivities, acute medication and repeat medication.

**Detailed Coded Record gives access to a summary of the patient's demographics allergies/adverse reactions, drug sensitivities, acute and repeat medication, immunisations, test results, coded problems, diagnoses, procedures, coded referrals and letters received (excluding free text, letters and attachments, administrative items)

Section 3 – Rationale for request

Please provide detailed reason(s) to substantiate your request for proxy access:

Section 4 – Online access

I / we……
(Name of requester/s) wish to have access to the services as outlined in section 2.

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

Statements
I/we have read and understood the information leaflet provided by the Practice and agree that I 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 Practice as soon as possible. I will treat any information which is not about the patient as being strictly confidential.
I / we…… (Name of requester/s) wish to have access to the services as outlined in section 2.

The Patient - (This is the person whose records are being accessed)

Name:	Date of Birth:
Address:	
Email Address:	
Contact Number:	

The Representative/s – (Those seeking proxy access for aforementioned patient's online records, appointment information and repeat prescriptions

Name:	Name:
Date of Birth:	Date of Birth:
Address:	Address:
Email Address:	Email Address:
Contact Number:	Contact Number:

FOR PRACTICE USE ONLY

PART A: AT TIME OF HANDING IN FORM:
Patient NHS Number:
Identity Verified By:
Method of Verification:
Date: