North Road Suite

RAVENSTHORPE HEALTH CENTRE

Application to allow my nominated person PROXY ACCESS to my Online Services and or to my Medical Records

PATIENT DETAILS

Surname	Date of birth
First name	
Address Postcode	
Email address:	@
Telephone number	Mobile number

NOMINATED PERSON WHO WILL HAVE PROXY ACCESS

Surname	Date of birth	
First name	Relationship to patient: ……	
Address Postcode		
Email address:	@	
Telephone number	Mobile number	
Is the patient registered at NRS please tick	Yes ( )	No ( )
Please ensure that the proxy person is recorded in groups and relationships in both records	Completed Yes ( ) By:	

I wish to have the above nominated person to have proxy access to the following online services on my behalf (please tick all that apply):

1. Booking appointments	☐
2. Requesting repeat prescriptions	☐
3. Accessing my medical record	☐
4. To be able to submit messages or questions on my behalf	☐

I have read and understand and agree with each statement (tick)

1. I have read and understood the information leaflet provided by the practice	☐
2. I will be responsible for the security of the information that I see or download	☐
3. If I choose to share or grant proxy access to my information with anyone else, this is at my own risk	☐
4. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	☐
5. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible	☐
6. I UNDERSTAND THAT I CAN INSTRUCT THE PRACTICE TO REMOVE THE PERSON I HAVE NOMINATED AS PROXY ACCESS IF I WISH TO DO SO AT ANY TIME BY CONTACTING THE PRACTICE MANAGER – LYNNE BOLTON	☐

PATIENT CONSENT

Signature: Print full name:	Date

Proxy access agreement over page: Cont;

PROXY ACCESS PERSON AGREEMENT OF TERMS AND CONDITIONS

I have agreed to be the proxy access to the online record as the nominated person for the named patient in this document and I confirm that have and understand and agree with each statement (tick) and that I will comply with all of the terms and conditions.

1. I have read and understood the information leaflet provided by the practice	☐
2. I will be responsible for the security of the information that I see or download	☐
3. I will **not** share my information with anyone else.	☐
4. I will contact the practice as soon as possible if I suspect that the account has been accessed by someone else.	☐
5. 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	☐
6. I UNDERSTAND THAT THE PATIENT CAN INSTRUCT THE PRACTICE TO REMOVE ME AS THE PERSON NOMINATED AS 'PROXY ACCESS' FOR PARTIAL OR ALL ACCESS RIGHTS IF THEY WISH TO DO SO AT ANY TIME BY CONTACTING THE PRACTICE MANAGER – LYNNE BOLTON	☐

Signature: Print full name:	Date

For practice use only RECORDING OF ID OF PROXY ACCESS USER.

Patient NHS number		**Practice computer ID number**
Identity verified by (initials)	**Date**	**Method** **Photo ID and proof of residence ☐** ***(All NRS REGISTRATIONS REQUIRE THE ABOVE) VOUCHING WILL ONLY BE USED IN VERY LIMITED CIRCUMSTANCES THIS IS FOR THE PATIENT AND PRACTICE PROTECTION)*** **Vouching ☐** **Vouching with information in record ☐**
Authorised by		**Date**
Date account created		
Date password/login details given		
Level of record access enabled **Prospective ☐** **Retrospective ☐** **All ☐** **Limited parts ☐** **(appointment booking only)Contractual minimum ☐**		**Notes / explanation**

THIS DOCUMENT NEEDS TO BE SCANNED TO THE PATIENT RECORD AND IF THE PROXY ACCESS PERSON IS REGISTERED AT NRS TO THEIR RECORDS AS WELL THEN FILLED IN THE ONLINE A TO Z REGISTRATION FORM FILE.