Richmond Hill Practice LTD

Online access application form – OTHER

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.

- Proxy access application will not be accepted from any third party commercial company i.e. insurance company or solicitors.

Section 1

Date: _____

Details of the person's medical records that will be accessed

Full name:	Date of Birth:
Address:	

I wish to give access to following online services:

1. Booking appointments	❑
2. Requesting repeat prescriptions	❑
3. Limited access to parts of my detailed medical record e.g. test results, immunisations, problems and allergies.	❑

By signing your signature below, you agree to the following statements;

I am the person in section 1 and give permission to the Gp practice to give PROXY access to online services to the person named 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 leaflet provided by the practice.

Signature of patient in section 1: _____

Section 2

The representative – the person who will have access

Full name:	Date of Birth:
Address:	
Relationship to patient:	
Email: (I would like you to email me the registration details when they are ready)	
Contact number: (I would like you to contact me when the registration details are ready to collect)	

1. I have read and understood the information leaflet provided by the practice and agree that I will treat the 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/we 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/we will contact the practice as soon as possible. I will treat any information which is not about the patient as being strictly confidential.	☑

By signing your signature below you agree with the following statements;

I am the person in section 2 and I will safeguard the information of the person in section 1 that I have been trusted with.
I understand my/our responsibility for safeguarding sensitive medical information and
I understand and agree with each of the following statements:

Signature of person named in section 2: _____

You MUST give us proof of identification for BOTH parties

Application forms may take up to 3 weeks to be processed*