**St Mary Street Surgery**

**Application for Proxy Access to a Patient’s Medical Records**

**Please note**

**This form is applicable to all persons over the age of 11. The patient granting proxy access will need to be present when the form is handed in. Photo ID of both patient and representative will be required.**

**Section 1**

**The Patient**

(This is the person whose records are being accessed)

|  |  |
| --- | --- |
| Surname | Date of birth |
| First name |
| Address  Postcode  |
| Email address |
| Telephone number | Mobile number |

**Section 2 ( if applicable)**

I believe the patient I am applying for proxy access to their medical record**, does not have the capacity to consent to grant proxy access.**

|  |  |  |
| --- | --- | --- |
| Please Tick [ ]  | Signature ofRepresentative(s)  | Date |

**Office Only : Please forward onto GP to complete**

I, ………………………………………………….( The GP ) agree the patient **does not have** capacity to consent to grant proxy access and proxy access is considered in my opinion to be in the patient’s best interest.

|  |  |
| --- | --- |
| Signature of GP | Date |

**Section 3**

I/We are requesting proxy access to the patient’s medical record. Please tick which type of access is required.

|  |  |  |  |
| --- | --- | --- | --- |
| 1. | Online access to the patient’s medical record | Laboratory Test Results |  |
|  | \*Please note restricted view is in place | Documents |  |
|  |  | Immunisations |  |
|  |  | Consultations |  |
|  |  | Problems |  |
|  |  | Booking GP Appointments |  |
|  |  | Requesting Repeat Prescriptions( you cannot request acute or past medications) |  |
|  |  | Allergies |  |
| 2. | General access to the patient’s medical record  | The clinicians and staff of St Mary Street Surgery will be allowed to discuss the medical problems of the patient with the representative(s). This might include: Results/Consultations/Referrals/Medication/ Documents etc. This can be done over the phone or in person |  |
|  |  |
|  |  |

Please note

If the Representative(s) is/are applying for online proxy then they must have their own Online Account set up so proxy access can be linked. Only one Representative can be linked to the patient’s online account.

**Section 4**

I, ………………………………………………….. (name of patient), give permission to St Mary Street Surgery to give the following representative(s):

………………………………………………..………………………………………………

proxy access to my full medical records and for online access account as indicated in Section 3.

* 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 Patient Information leaflet provided by the practice

|  |  |
| --- | --- |
| Signature of patient | Date |

**Section 5**

**The Representatives**

(These are the people seeking proxy access to the patient’s medical record)

**Representative 1** **Representative 2**

|  |  |
| --- | --- |
|  Surname | Surname |
| First name | First name |
| Date of birth | Date of birth |
| AddressPostcode  | Address (tick if both same address [ ] )Postcode |
| Email | Email |
| Telephone | Telephone |
| Mobile | Mobile |

I/We……………………………………………………………………………………………

…………………………………………………………………………………………………

(names of representatives) wish to have access to the services ticked in the box above in section 3 for

………………………………………………….……………………………… (name of patient).

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

|  |  |  |
| --- | --- | --- |
| 1. | I/We have read and understood the Patient Information leaflet provided by the practice and agree that I/We will treat the patient’s information as confidential | [ ]  |
| 2. | I/We will be responsible for the security of the information that I/We see or download | [ ]  |
| 3. | I/We will contact the practice as soon as possible if I/We suspect that the online access account has been accessed by someone else without my/our/the patient’s prior agreement  | [ ]  |
| 4. | If I/We see information in the medical record that is not about the patient, or is inaccurate, I/We will contact the practice as soon as possible. I/We will treat any information which is not about the patient in strict confidence | [ ]  |

|  |  |
| --- | --- |
| Signature/s of Representative/s  | Date/s |

**For Practice use only**

The Patient **MUST** be present when I.D is verified

* **Please note**: If the patient does not have capacity or is housebound/ in care home they do not need to be present when ID is verified. (Please see the guidance notes under the heading “ Proxy Access to Patients Medical Notes)

The Patient **AND** Representative/s identification must be verified.

|  |  |
| --- | --- |
| The Patient’s NHS number | Emis Number |
| Identity verified by(initials) | Date | Method of verificationVouching Vouching against information in patients record Photo ID ( Drivers Licence or Passport) \* Proof of address is not needed **only** photo I.D (this is needed to prove who they are) | Patient[ ] ­­­[ ] [ ]  | Rep 1 [ ] ­­­[ ] [ ]  | Rep 2[ ] ­­­[ ] [ ]  |
| Proxy access authorised by  | Date |
| Online proxy access linked Yes/No |
| Proxy Access Patient Warning created on EMIS Yes/No |