Quorn Medical Centre

Consent to proxy access to Detailed Medical Record – DCR
(For new online proxy account holders)

Instructions:
Please complete the fields below and present it to reception along with 2 forms of ID e.g. photo ID and proof of residence. (Proof of residence must not be older than 3 months).

Approval Process:
Applications for this service may take up to 28 days subject to approval by a GP. However the surgery has the right to refuse an application based on the best interests of the patient.

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.

Section 1

I,…….. (name of patient), give permission to my GP practice to give the following people ……..…….. proxy access to the online services as indicated below 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

Approval Process:
Applications for this service may take up to 28 days subject to approval by a GP. However the surgery has the right to refuse an application based on the best interests of the patient.

Signature of patient	Date

Section 2

1. Online appointments booking	☐
2. Online prescription management	☐
3. Accessing the medical record for (name of patient)	☐

Section 3

I/we…….. (names of representatives) wish to have online access to the services ticked in the box above in section 2

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 information leaflet provided by the practice and agree that I will treat the patient 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 account has been accessed by someone without my/our agreement	☐
4. 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	☐

Signature/s of representative/s	Date/s

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

The representatives

(These are the people seeking proxy access to the patient's online records, appointments or repeat prescription.)

Surname	Surname
First name	First name
Date of birth	Date of birth
Address Postcode	Address (tick if both same address ☐) Postcode
Email	Email
Telephone	Telephone
Mobile	Mobile

For practice use only

The patient's NHS number		The patient's practice computer ID number
Identity verified by (initials)	Date	Method of verification Vouching ☐ Vouching with information in record ☐ Photo ID and proof of residence ☐
Proxy access authorised by		Date
Date account created		
Date passphrase sent		
Level of record access enabled Prospective ☐ Retrospective ☐ All ☐ Limited parts ☐ Contractual minimum ☐		Notes / comments on proxy access GP Approved for online access ☐ GP Declined for online access ☐

Code added to patient record: Approved (9lw) ☐ Declined (9lx) ☐

Clinical Record checked by Dr _____ Date:_____

Administration fields checked by _____ Date:_____