THE LYNDHURST SURGERY
53 LYNDHURST DRIVE, LEYTON, LONDON, E10 6JB

Tel no: 020 8539 1663 - Fax: 020 85561977

ON LINE SERVICES PATIENT REGISTRATION FORM –CONSENT TO PROXY ACCESS

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.

Signature of patient	Date

Section 2

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

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	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	5.	☐

Signature of representative	Date

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The patient

(This is the person whose records are being accessed)

Surname			
First name			
Date of birth			
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

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 below Read Code added to patient's medical record: Proxy has online access to patient record		
Level of record access enabled (tick below):		
All ☐ Test Results ☐ Documents ☐ Immunisations ☐ Problems ☐ Consultations ☐		Notes /Comments on proxy access

Date patient informed about registration details: Read code **9N3C** (Email sent to patient) added to patient's medical records	