Ibstock & Barlestone Surgeries
Traditional Values, Modern Healthcare

SystmOnline 'Proxy' Application Form

Please note that the Practice has the right to deny 'proxy' access.

Section 1: (to be completed by the patient if over 13 years old, or deemed to have capacity to grant 'Proxy' access)

Patient Details:

Title:		First name:		Surname:	

Date of Birth:	

Address:				
Home number:		Mobile number:		I consent for the practice to contact me via SMS text message ☐
E-mail address:			I consent for the practice to contact me via email ☐	

I wish to grant access to the following SystmOnline service(s) to the person(s) listed below.

☐ **Summary Record Access**
Appointment Management ☐
Prescription Management ☐
Summary Care Record (SCR) ☐

☐ **Detailed Coded Record (DCR) Access**** *(16 years and over only)*
Appointment Management ☐
Prescription Management ☐
Summary Care Record (SCR) ☐
Coded Entries ☐

For further information on the services available please refer to the SystmOnline Information leaflet

I reserve the right to reverse any decision I make in granting 'Proxy' access to another person(s) at any time.

I understand the risks associated with allowing another person(s) having access to my SystmOnline account.

I have read and understood information, terms and conditions contained within this application form provided by the Practice.

Patient Signature:		Date:	

Please turn over

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Section 2: (to be completed by the Proxy(s))
Proxy details:

Proxy 1	Proxy 2
Proxy Full Name:	Proxy Full Name:
Relationship to patient:	Relationship to patient:
Date of Birth:	Date of Birth:
Address: (if different to patient's)	Address: (if different to patient's)
Home number:	Home number:
Mobile number:	Mobile number:
E-mail address:	E-mail address:

I / We wish to have access to the aforementioned patient's SystmOnline service(s).

- ☐ I / we have read and understood the information leaflet and terms and conditions provided to me by the practice and agree that I will treat the patient information as confidential.
- ☐ I/we will be responsible for the security of the information that I/we view, download or print.
- ☐ 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.

Proxy 1 Signature:		**Date:**	
Proxy 2 Signature:		**Date:**	

By signing this application form you have agreed to the terms and conditions outlined in the Information Leaflet Provided

FOR PRACTICE USE ONLY:

Staff Member:	**Date:**
Type(s) of ID seen: **Proxy 1:** **Proxy 2:**	**ID number(s):** **Proxy 1:** **Proxy 2:**
'Proxy' access reviewed by:	**'Proxy' access granted / denied:**
Level of 'Proxy' access enabled: (please tick) ☐ Full record ☐ Partial record ☐ Contractual Minimum ☐ Prospective ☐ Retrospective	**'Proxy' access notes / comments:**