

Castle Donington Surgery

53 Borough Street, Castle Donington, Derby, DE74 2LB
01332 856050

Application for Patient Online Access – PROXY ACCESS REQUEST

Patient details – who is granting access

Surname:	First name:
Date of Birth:	
Address:	Postcode:
Email address:	
Home telephone number:	Mobile number:

Carer / others details – who is being given access

Surname:	First name:
Date of Birth:	
Address: (If different from patient)	Postcode:
Email address:	
Home telephone number:	Mobile number:

I wish to give the following online services / access to the person named above

Appointment booking	☐
Prescription requesting	☐
!!Password reset only!!	☐
Access to medical records – **NOT RECOMMENDED FOR PROXY ACCESS**	
1. Your "Summary Care Record"	☐
2. Detailed Coded Records (coded data entered from April 2015 onwards)	☐
3. Full access to medical records (entries made from this day forward)	☐

FULL RETROSPECTIVE ACCESS TO YOUR MEDICAL RECORD IS CURRENTLY NOT AVAILABLE AT THIS PRACTICE

I understand and agree with each statement (please tick):

1. I understand that requests to access medical records may take up to 28 days to be completed	☐
2. I have read and understood the information leaflet provided by the practice	☐
3. I will be responsible for the security of the information that I see, print or download	☐
4. If I choose to share my information with anyone else, this is at my own risk	☐
5. If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible	☐
6. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible	☐
7. If I think that I may come under pressure to give access to someone else unwillingly I will contact the practice as soon as possible	☐

Patient Signature:	**Date:**



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PROXY ACCESS REQUEST

!!FOR PRACTICE USE ONLY!!

Patient NHS number:	**Patient identification verified by (Print Name):**
Date:	**Method:** **Vouching ☐** **Vouching with information in record ☐** **Photo ID and proof of residence ☐**
Authorised by:	**Date:**
Date account created:	
Date passphrase sent to patient:	
Level of record access enabled: **Appointment ☐** **Prescriptions ☐** **Access to records or summary care records not recommended for PROXY access** **Summary Care Records ☐** **Detailed coded records ☐** **Full PROSPECTIVE records ☐** **Other – See notes ☐**	**Notes / explanation:**
Clinically Assured by: (if needed)	**Date:**
Reason for refusal if record access is refused after clinical assurance:	