

# EMPINGHAM MEDICAL CENTRE

## Application for online PROXY access to my detailed coded medical record

### YOUR DETAILS:

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

### YOUR PROXY'S DETAILS:

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

I wish my proxy to have access to the following online services (please tick all that apply):

1. Booking appointments	<input type="checkbox"/>
2. Requesting repeat prescriptions	<input type="checkbox"/>
3. Accessing my medical record	<input type="checkbox"/>

I wish my proxy to access my medical record online and I/we understand and agree with each statement (tick):

1. I/we have read and understood the information leaflet provided by the practice	<input type="checkbox"/>
2. I/we will be responsible for the security of the information that I see or download	<input type="checkbox"/>
3. I/we will contact the Practice as soon as possible if I/we suspect that my account has been accessed by someone without my/our agreement	<input type="checkbox"/>
5. If I/we see information in my record that is not about me or is inaccurate, I/we will contact the Practice as soon as possible	<input type="checkbox"/>

Signature	Date
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**For practice use only**

Patient NHS number		Practice computer ID number	
Identity verified by (initials)	Date	Method Vouching <input type="checkbox"/> Vouching with information in record <input type="checkbox"/> Photo ID and proof of residence <input type="checkbox"/>	
Authorised by			Date
Date account created			
Date passphrase sent			
Level of record access enabled		Notes / explanation	
All <input type="checkbox"/> Prospective <input type="checkbox"/> Retrospective <input type="checkbox"/> Detailed <input type="checkbox"/> Limited parts <input type="checkbox"/> Contractual minimum <input type="checkbox"/>			