Appendix B - Consent for Proxy Access to a Detailed Coded Record (DCR)

Section 1 – the patient (whose on-line DCR is to be accessed)	
Surname:	**Forename(s):**
Date of birth:	**Gender:**
Address: **Postcode:**	
Tel. number:	**Mobile number:**

Section 2 – the representatives (those requiring proxy access to the patient's DCR)	
Surname:	**Surname:**
Forename(s):	**Forename(s):**
Date of birth:	**Date of birth:**
Address: **Postcode:**	**Address:** **Postcode:**
Tel. number:	**Tel. number:**
Mobile number:	**Mobile number:**

Note : If the patient does not have capacity to consent to proxy access but such proxy access would be considered by the Health Centre to be in the patient's best interest, Section 3 may be omitted

Section 3 – patient's permission	
I,_____ (name of patient), give permission to Oak Tree Health Centre to grant the person(s) named in Section 2 above proxy access to my on-line Detailed Coded Record (DCR). I reserve the right to reverse at any time any decision I make in granting proxy access. I understand the risks of allowing someone else to have access to my health records. I have read and understood the Patient Information Leaflet (Appendix C) provided by the Health Centre.	
Signature of patient:	**Date:**

/cont…

Appendix B (Cont)- Consent for Proxy Access to a Detailed Coded Record (DCR)

Section 4 – the representatives' declaration		
I/we would like to request on-line access to the Detailed Coded Record (DCR) of the patient identified in Section 1 above. This will allow me/us to see records of their health problems, medications, laboratory test results, documents, allergies, consultations and immunisations. **Please read each of the statements 1 to 5 and declare your agreement by ticking the ☐...**		
1	I/we have read and understood the Patient Information Leaflet (Appendix C) provided by the Health Centre	☐
2	I/we will be responsible for the information I/we see on-line or download	☐
3	If I/we choose to share the information with anyone else this is done at my/our own risk	☐
4	I/we will contact the Health Centre as soon as possible if I/we suspect that the account has been accessed by someone else without my/our agreement	☐
5	I/we will contact the Health Centre as soon as possible if I/we see information in the record which is not about the patient identified in Section 1 or is inaccurate. I will treat any information which is not about the patient as being strictly confidential.	☐
Signature(s):	**Date:**	

For Health Centre use only				
Patient EMIS #		**Patient NHS #**		
Identity Verification	**By:** **Date:**	**Vouching by Member of Staff:**		☐
		Vouching Against Information in the Care Record:		☐
		Photo ID and Proof of Residence:		☐
Reviewed	**By:** **Date:**	**Authorised**	**By:** **Date:**	
Notes			**Approve**	☐
			Decline	☐