**Pulborough Medical Group, Spiro Close, Pulborough West Sussex RH20 1FG**

**ACCESS TO INFORMATION AND RECORDS**

We take patient confidentiality very seriously however we appreciate that, for some patients, it is useful for them to nominate a representative who has some access to your information.

We have two levels of access which you can authorise: basic and advanced

**LEVEL 1 - BASIC ACCESS**

This access is ideal to give spouses / partners and parents who call on behalf of their adult children and allow them to do the following on your behalf:

* Book / check / alter appointments
* Request a repeat prescription.
* Check if a prescription is ready, what has been prescribed and collect it on their behalf

This level does not allow the surgery to share information in regards to any medical conditions

**LEVEL 2 – ENHANCED ACCESS**

This access is ideal for patients who have carers who support their day to day lives and gives access to all areas of your information. We would expect the representative to be able to speak on your behalf and for the surgery to liaise with them where necessary.

Please let us know if your representative is also your carer so we can make a note of it. We can often offer additional support and advice to carers.

**STOPPING ACCESS**

If you wish to change or stop the access your representative has you must complete an ACCESS REMOVAL FORM – please remember it is your responsibility to stop or change access rites and the surgery will not remind you to review any access arrangements you have made.

**ACCESS TO INFORMATION AND RECORDS – APPLICATION FORM**

|  |  |
| --- | --- |
| **Patient Details** | |
| **Full Name** |  |
| **Address** |  |
| **Post Code** |  |
| **Tel No.** |  |
| **Date of Birth** |  |



|  |  |
| --- | --- |
| **Representative Details** | |
| **Full Name** |  |
| **Address** |  |
| **Post Code** |  |
| **Tel No.** |  |
| **Relationship to patient** |  |

I agree that the person signed below is able to have the access to information held by Pulborough Medical Group as indicated above.

Patient Signature: …………………………………………………………. Date: ………………………….

Representative Signature: ………………………………………………….. Date: …………………………..

Witness Signature:………………………………………………………………… Date:………………………………

Witness Name:……………………………………………………………………………………………………………………

Witness Address:………………………………………………………………………………………………………………..

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By signing this form you are consenting to your details being kept by Pulborough Medical Group

**Pulborough Medical Group accepts no responsibility for false information given by any of the above persons**