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Annex A – Preferences for text messaging service

MGS Medical Practice Patient Text Communication Preferences

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

My text communication preferences are: (please tick all that apply):

Give consent for communication by SMS text messaging	
Give consent to receive test results by SMS text messaging	
Declined consent to receive test results by SMS text messaging	

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

I will be responsible for the security of the information that I receive	
If I choose to share my information with anyone else, this is at my own risk	
I will contact the practice as soon as possible if I suspect that my information has been accessed by someone without my agreement	
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	

Signature:		**Date:**	

Annex B – Consent to proxy access for text messaging services

MGS Medical Practice Consent to Proxy Access for Text Messaging Services

Note: If the patient does not have capacity to consent to grant proxy access and proxy access is considered by the practice to be in the patient's best interest, Section 1 of this form may be omitted

Section 1 – Patient declaration

I……(name of patient), give permission to MGS Medical Practice to give the person/people indicated below proxy access to the text messaging services as indicated below in Section 2.

- I reserve the right to reverse any decision I make in granting proxy access at any time
- I understand the risks of allowing someone else to have access this information

Signature of patient:		**Date:**	

Section 2 – Consent options

Give consent for communication by SMS text messaging	
Give consent to receive test results by SMS text messaging	

Section 3 - The representatives

(These are the people seeking proxy access to the patient's online records, appointments or repeat prescription)

Surname		**Surname**	
First name		**First name**	
Date of birth		**Date of birth**	
Address		**Address**	
Postcode		**Postcode**	
Email		**Email**	

Telephone		**Telephone**	
Mobile		**Mobile**	

Section 4 - The patient (If the patient does not have capacity)

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

Section 5 – Representative Declaration

I/We …….…… (names of representatives) wish to have access to the information ticked in the box above in Section 2 for …… (name of patient)

I/We understand my/our responsibility for safeguarding sensitive information and I/We understand and agree with each of the following statements:

I/We will be responsible for the security of the information that I/we see	
I/We will contact the practice as soon as possible if I/we suspect that the information has been accessed by someone without my/our agreement	

Signature(s) of representative(s):		**Date(s):**	
Signature(s) of representative(s):		**Date(s):**	
Signature(s) of representative(s):		**Date(s):**	
Signature(s) of representative(s):		**Date(s):**	

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Annex C – Text messaging access process for 11 to 16 years