South Milford Surgery

Consent to Proxy Access to GP Online 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. Proxy access application **will not** be accepted from any third-party commercial company i.e Insurance company or solicitors.

Proxy Access
Parents may request a proxy access to their children's records; this will cease automatically when the child reaches the age of **13**. Any subsequent Proxy Access will need to be authorised by the patient subject to a Gillick competency test being completed by a GP.

Section 1

I,…… (*Name of patient*), give permission to my GP practice to give the following person/s Proxy access to the online services indicated below in Section 2.

Name of 1st Representative: ……

Name of 2nd Representative: ……

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 to my health records.
I have read and understand the information leaflet provided by the practice

Patient Signature		**Date**	

Section 2

1	Online appointment booking	☐
2	Online prescription management	☐

Section 3

I/we, the representative/s named above in Section 1, wish to have Proxy Access to the services ticked in the box above in Section 2 for (*patients name)*>
I/we understand my/our responsibility for safeguarding sensitive medical information and I/we understand and agree with each of the following statements:

1	I/we have read and understood the information leaflet provided by the practice and agree that I/we will treat the patient information as confidential	☐
2	I/we will be responsible for the security of the information that I/we see or download	☐
3	I/we will contact the practice as soon as possible if I/we suspect that the account has been accessed by someone without my/our agreement	☐
4	If I/we see information in the record that is not about the patient, or is inaccurate, I/we will contact the practice as soon as possible. I/we will treat any information which is not about the patient as being strictly confidential	☐

Signature/s of Representative/s		**Date**	
		Date	

The Patient

(This is the person whose records are being accessed)

Surname			
First name		**Date of birth**	
Address **Postcode**			
Email address			
Telephone No.			
Mobile No.			

The Representatives

(This is the person(s) seeking proxy access to the patient's online records as indicated in Section 2 above)

Representative 1		**Representative 2**	
Surname		**Surname**	
First name		**First name**	
Date of birth		**Date of birth**	
Address **Postcode**		**Address** *(tick box if both same address ☐)* **Postcode**	
Email		**Email**	
Tel No.		**Tel No.**	
Mobile No.		**Mobile No.**	

When complete, bring into the surgery with **two** forms of identification. One form of photo ID and one proof of address i.e. Passport, Photo Driving Licence, Photo Bus pass, Student ID **and** one official letter bearing your name and address i.e. Bank or Building Society, Utility Company, Local Council, Landline Telephone Provider.
(**Note:** A photo driving licence will suffice for both photo ID and proof of address)

For Practice Use Only

Patient NHS Number:		Identity Verification Method	
ID verified by:	Date:	Driving Licence ☐ Passport ☐ Bus Photo Pass ☐ Student ID ☐	
Authorised by *(if applicable)*:	Date:	Bank/Building Scty ☐ Local Council ☐ Utility Co. ☐ Landline Provider ☐ Other (please state)	
Date account created		Date Passphrase sent	
Level of record access enabled 1,2,3,4 (as indicated above in Section 2) ……	Notes / comments on Proxy Access:		