

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	
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Section 2

1	Online appointment booking	<input type="checkbox"/>
2	Online prescription management	<input type="checkbox"/>

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	<input type="checkbox"/>
2	I/we will be responsible for the security of the information that I/we see or download	<input type="checkbox"/>
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	<input type="checkbox"/>
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	<input type="checkbox"/>

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		Address	<i>(tick box if both same address <input type="checkbox"/>)</i>
Postcode		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 <input type="checkbox"/>	Passport <input type="checkbox"/>
		Bus Photo Pass <input type="checkbox"/>	Student ID <input type="checkbox"/>
Authorised by (if applicable):	Date:	Bank/Building Scty <input type="checkbox"/>	Local Council <input type="checkbox"/>
		Utility Co. <input type="checkbox"/>	Landline Provider <input type="checkbox"/>
		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:		
.....			