

PROXY ACCESS APPLICATION FORM

(For children aged 0 – 10 years)

Please complete a separate form for each child 0 – 10 years old that you require proxy access for.

I/we (names of parents/guardians)
wish to have proxy access to online services for my/our child detailed below.

Surname	
Forename	
Title	
Date of Birth	
Address	
Address	
Address	
Post code	
Home phone No	
Mobile phone No	
Email address	

Declaration: I/we understand my/our responsibility for safeguarding sensitive medical information.

By registering me/us for proxy PatientAccess to medical records at Fernville, I agree to follow all instructions on how to use the system and only to use it for the benefit of my/our child. I will not divulge the logon details to another person.

Signed.....Date

Name in caps.....

Keep the details on this form safe until your proxy access is confirmed and destroy them safely afterwards. We do not want to risk third parties gaining access to the details and potentially to the medical records.