**Application for Proxy Online Access – Parent**

***For Data Protection purposes, online access is only available for children up to the age of 11.***

***The named patient/guardian must return this form in person, along with photo ID – eg passport/drivers licence***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Child’s details** | | | | | |
| Title |  | First Name |  | Last name |  |
| Gender | Male / Female | | | Date of Birth |  |
| Address | | Postcode | | | |
|  | | | | | |
| NHS Number | | |  | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Parent applying for access** | | | | | | | | | | | | | | | | |
| First Name | | | |  |  |  | |  | | | | |  | | | |
| Last Name | | | | | |  | |  | | | | |  | | | |
| Relationship to child | | | | | |  | | | | | | | | | | |
| **Parent Details** | | | | | | | | | | | | | | | | |
| Email Address | | | | | | |  | | | | | | | | | |
| Home Telephone Number | | | | | | | Mobile Number | | | | | | | | | |
|  | | | | | | | | | | |
| **Access requested *(PLEASE TICK all that apply)*** | | | | | | | | | | | | | | | | |
| Repeat prescriptions | | | | | |  | |  | | | | |  | | | |
| Accessing Medical record | | | | | |  | | | | | | | | | | |
|  | |  | | | | | | | | | | | | | | |
| **I WISH TO ACCESS MY CHILD’S MEDICAL RECORD ONLINE. I UNDERSTAND AND AGREE WITH EACH STATEMENT *(PLEASE TICK all of the below)*** | | | | | | | | | | | | | | | | |
| I have read and understood the information leaflet provided the Practice. | | | | | | | | | | | | | |  | | |
| I will be responsible for the security of the information that I see or download. | | | | | | | | | | | | | |  |  | |
| 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 account has been accessed by someone without my agreement. | | | | | | | | | | | | | |  |  | |
| If I see information in my child’s record that is not about my child or is inaccurate, I will contact the practice as soon as possible. | | | | | | | | | | | | | |  | | |
| **Signature** | | | | | | | | |  | **Date** | | | |  | | |
|  | |  | | | | | | | | | | | | | | |
|  | | |  | | | | | | | | | | | | | |
| **FOR OFFICE USE:** | | | | | | | | | | | | | | | | |
| Photo ID Type |  | | | | | | | | | | | Verified by: | | | |  |
|  | | | | | | | | | | | | Date: | | | | |
| Done and coded | | | | |  | Date coded: | | | | | | Initials: | | | | |