**Application for Proxy Online Access - Carer**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Patient for which access is being requested** | | | | | | | | |
| Title |  | | First Name |  | | Last name |  | |
| Gender | Male/Female | | | | | Date of Birth |  | |
| Address |  | | | | | | | |
| **TO BE COMPLETED BY *PATIENT*** | | | | | | | | |
| **I give permission to Knoll Medical Practice to give the below named individual/s proxy access to the online services as indicated below.**  **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 and I have read and understood the information leaflet provided by the practice.** | | | | | | | | |
| I grant permission to allow access to book appointments and order repeat prescriptions **only** | | | | | | | |  |
| I grant permission to allow access to book appointments, order repeat prescriptions and view online medical records | | | | | | | |  |
| **\*Signature** | |  | | | | | **Date** |  |
| Name and relationship (if signed on behalf of patient) | | | | |  | | | |

**\*If the patient does not have capacity to consent this should be signed by the person holding lasting power of attorney for health and welfare or by the GP.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Proxy Users applying for access** | | | | | |
| Title |  | First Name |  | Last name |  |
| Gender | Male/Female | | | Date of Birth |  |
| Address |  | | | | |
| Email |  | | | | |
| Relationship to Patient | | |  | | |
| Title |  | First Name |  | Last name |  |
| Gender | Male/Female | | | Date of Birth |  |
| Address |  | | | | |
| Email |  | | | | |
| Relationship to Patient | | |  | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **TO BE COMPLETED BY THE *PROXY USER/USERS* APPLYING FOR ACCESS** | | | | | | | |
| **I/we understand my/our responsibility for safeguarding sensitive medical information and understand and agree with the following statements *(please tick to indicate agreement):*** | | | | | | | |
| I/we will be responsible for the security of the information that I/we see or download. | | | | | |  | |
| I/we will contact the practice as soon as possible if I/we suspect that the account has been accessed by someone without the patient’s agreement. | | | | | |  | |
| 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** |  | | | **Date** |  | | |
| **Signature** |  | | | **Date** |  | | |
| **FOR OFFICE USE:** | | | | | | | |
| Photo ID Type Verified by: | | | | | | |  |
|  | |  | Date seen: | | | | |
| Done and coded | |  | Date coded: Initials: | | | | |