**Application for Proxy Online Access - Carer**

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| **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.**

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| **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 |  |

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| **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: |