**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.

**Section 1**

I,………………………………………………….. (name of patient), give permission to my GP practice to give the following people, ….………………………………………………………………..…………….. , proxy access to the online services as indicated below in section 2.

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.

|  |  |
| --- | --- |
| Signature of patient | Date |

**Section 2**

|  |  |
| --- | --- |
| 1. Online appointments booking
 | 🞏 |
| 1. Online prescription management
 | 🞏 |

We currently do not offer limited access to the patient’s medical records via proxy access. If you feel you require limited access to medical records via proxy access, please ask at reception when handing in this completed form. You will asked for further details as to why this is necessary, and the patient’s named GP will be involved in the decision as to whether it is in the best interest of the patient to grant this access. This does not affect your right to subject access under the Data Protection Act 1998.

**Section 3**

I/we…………………………………………………………………………….. (names of representatives) wish to have online access to the services ticked in the box above in section 2

for ……………………………………….……… (name of patient).

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 will treat the patient information as confidential
 | 🞏 |
| 1. I/we will be responsible for the security of the information that I/we see or download
 | 🞏 |
| 1. 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
 | 🞏 |
| 1. 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 will treat any information which is not about the patient as being strictly confidential
 | 🞏 |

|  |  |
| --- | --- |
| Signature/s of representative/s | Date/s |

**The patient**

(This is the person whose records are being accessed)

|  |  |
| --- | --- |
| Surname | Date of birth |
| First name |
| Address Postcode  |
| Email address | Consent for communication by email? 🞏 |
| Telephone number | Mobile number | Consent for communication by text message? 🞏 |

**The representatives**

(These are the people seeking proxy access to appointments and/or repeat prescriptions.)

|  |  |
| --- | --- |
| Surname | Surname |
| First name | First name |
| Date of birth | Date of birth |
| AddressPostcode  | Address (tick if both same address 🞏)Postcode |
| Email | Email |
| Telephone | Telephone |
| Mobile | Mobile |

**For practice use only**

|  |  |  |
| --- | --- | --- |
| Identity verified by(initials) | Date | Method of verification Vouching 🞏Vouching with information in record 🞏 Photo ID and proof of residence 🞏Specify…………………………………………………… |
| Proxy access authorised by  | Date |
| Date account created  |
| Level of record access enabled  Contractual minimum √Other…………………… | Notes / comments on proxy access |