**Consent to proxy access to GP online services**

**Notes**: 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.

If, as a parent, you are applying for access to your child’s records, we will need you to confirm your parental rights. If your child is competent and able to understand the implications of your access, then we will need to get their consent first even if they are under 16 years of age.

**Section 1**

I,………………………………………………….. (name of patient), Date of Birth…………………… 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.

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

**Section 2**

|  |  |
| --- | --- |
| 1. Online appointments booking
 | 🞏 |
| 1. Online prescription management
 | 🞏 |
| 1. Accessing the medical record for (name of patient)
 | 🞏 |

**Section 3**

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

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

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
 | 🞏 |
| 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
 | 🞏 |

|  |  |
| --- | --- |
| Signature of representative | Date |
| Signature of representative | Date |

If as a parent you are applying for access to your child’s records, please confirm your parental responsibility. At least one of the following must apply and your parental rights must not have been removed by the courts. Please tick to indicate which apply.

EITHER

 your name is on the birth certificate    OR

 if you are the father, you were married to the mother at the time of birth  OR

 you have been granted parental rights by the courts   OR

 if you are the father, you have the agreement of the mother

AND **□ my parental rights have not been removed by the courts**

Signature of parent………………………………Date………………………………………….

**The patient**

**(This is the person whose records are being accessed)**

|  |  |
| --- | --- |
| Surname | Date of birth |
| First name |
| Address  Postcode  |
| Email address |
| Telephone number | Mobile number |

**The representatives**

**(These are the people seeking proxy access to the patient’s online records, appointments or repeat prescription)**

|  |  |
| --- | --- |
| 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**

|  |  |
| --- | --- |
| The patient’s NHS number | The patient’s practice computer ID number |
| Identity verified by(initials) | Date | MethodVouching 🞏Vouching with information in record 🞏 Photo ID and proof of residence (tick below) 🞏passport 🞏driving licence 🞏bank statement 🞏other (please record) 🞏 |
| Proxy access authorised by**PLEASE NOTE THIS MUST BE A GP PARTNER** | Date |
| Date account created  |
| Date passphrase sent/handed out |
| Level of record access enabled  Appointments 🞏Repeat Prescriptions 🞏 Medication 🞏Allergies 🞏Other, please specify 🞏 | Notes / comments on proxy access |