ALTON STREET SURGERY

Alton Street, Ross-on-Wye, HR9 5AB
Telephone 01989 563646

Consent to proxy access to GP online services

The patient (The person whose records are being accessed)

Name: _____

Date of birth: _____

Address: _____

Email address: _____

Telephone number: _____

Mobile number: _____

Please tick all of the online services you wish to grant proxy access to:

- ○ Booking appointments
- ○ Requesting repeat prescriptions
- ○ Medication and allergies
- ○ Problems
- ○ Test results
- ○ Consultations
- ○ Immunisations
- ○ Detailed Coded Access to Records

Please tick all of the statements below if you agree with them:

- ○ I give permission for my GP practice to provide proxy access, for the services indicated to the representative listed overleaf.
- ○ 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: _____ Date: _____
(The patient)

Note: Only if the patient does not have capacity to sign this form can the form be completed by the representative seeking proxy access and this page left unsigned.

The representative (The person who is seeking proxy access to the patient's online record.)

Name: _____

Date of birth: _____

Address: _____

Email address: _____

Telephone number: _____

Mobile number: _____

Relationship to patient: _____

Please tick all of the statements below if you agree with them:

- ○ I understand my responsibility for safeguarding sensitive medical information.
- ○ I have read and understood the information leaflet provided by the practice and agree that I will treat the patient information as confidential.
- ○ I will be responsible for the security of the information that I see or download.
- ○ I will contact the practice as soon as possible if I suspect that the account has been accessed by someone without my agreement.
- ○ If I see information in the record that is not about the patient, or is inaccurate, I will contact the practice as soon as possible. I will treat any information which is not about the patient as being strictly confidential.

Signature: _____ Date: _____
(The representative)

For practice use only

Two forms of identification are required with at least one being photographic.

If applying online please note you will need to bring your identification into surgery before we can process your application

Please list identification seen:

- ○ Passport Number: _____ Issue Date: _____
- ○ Current Driving licence Number: _____ Issue Date: _____
- ○ Mortgage statement (Issued within 12 months)
- ○ Bank/Building Society Statement (UK) (Issued within 3 months)
- ○ Bank/Building Society Account Opening Confirmation Letter (UK)
- ○ Financial Statement (Issued within 12 months)
- ○ Credit Card Statement (UK) (Issued within 3 months)
- ○ UK Utility Bill/ Benefit statement/Document from Central/Local Government (Issued within 3 months) (Please note that we cannot accept mobile telephone statements)

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○ Other, please state: _____

Identification verified by: _____ Date: _____

Competency assessed: Yes / No Assessed by: _____ Date: _____

Proxy access authorised by: _____ Date: _____

Level of access granted by: _____