ATHERSTONE SURGERY - Residential Proxy Access form

Patient application for proxy access to online services including medical records

To be filled in regarding the patient:

First name	Date of birth
Surname	Telephone number:
Address Postcode	Mobile number: Consent to receive text messages: Yes/No
Email address: (Please write clearly)	

To be filled in regarding proxy user:

First name	Date of birth
Surname	Telephone number:
Address Postcode	Mobile number: Consent to receive text messages: Yes/No
Email address: (Please write clearly)	
Registered at this surgery? (Please delete as appropriate) Yes/No	Relationship to Patient:

I wish to allow my proxy to have access to the following online services (please tick all that apply):

1. Booking appointments	
2. Requesting repeat prescriptions	
3. Accessing a summary of my records (Medications, Allergy's & adverse reactions)	
4. Advanced unlimited access **(this will include records going back to birth, letters, consultations, results etc)**	

I understand and agree with each statement (tick)

1. I have read and understood the information leaflet provided by the practice	
2. I will be responsible for the security of the information I see or download	
3. If I choose to share my information with anyone else, this is at my own risk	
4. I will contact the practice A.S.A.P. if I suspect my account has been accessed by someone without my agreement	
5. If I see information in my record that is not about me or is inaccurate, I will contact the practice A.S.A.P.	
6. I consent to receive text messages from the practice for appointment reminders and health promotion	
7. I will be responsible for informing the practice of any changes to my mobile telephone number	

Patient's Signature of Consent	**Date:**

Proof Of Patients Consent: (FOR PRACTICE USE ONLY)

Patients ID verified as proof of consent by (initials):	**Date:**	**Method:** **(if child is UNDER 11yrs this must be provided!) Birth Certificate Seen** ☐ **Vouching** ☐ **Photo ID and proof of residence** ☐ **(if child is OVER 11yrs this must be provided!) Child gave verbal consent** ☐

Proof Of Proxy's Identity:

Prox's ID verified by (initials):	**Date**	**Method:** **Vouching** ☐ **Vouching with information in record** ☐ **Photo ID and proof of residence** ☐
Authorised by		**Date**

Please note that this form MUST be verified by ID from both the patient AND the proxy.