Patient Online Proxy Access Application Form

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

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

1. Booking appointments	☐
2. Requesting repeat prescriptions	☐
3. Access patient medical records	☐

I wish to access the medical records of the following patients

Surname	First name	Date of birth	Relationship to patient

If more space is needed, please use another form.

Declaration

I declare that I have obtained consent from the above patients or if the patient(s) are/is unable to provide consent, that I am their legal parent/guardian or I have responsibility for their healthcare.

Signature	Date

For practice use only

Applicant identity verified by	Date	Method Vouching ☐ Vouching with information in record ☐ Photo ID and proof of residence ☐
Authorised by manager		Date

Proxy code added to patients record ☐ (1980711000006103) Letter sent to patients home address ☐	Verbal consent of patient obtained ☐ Written consent of patient saved in records ☐ Applicant has responsibility for patient care ☐ Consent not given ☐