**Consent to proxy access to GP services**

**FOR SOMEONE ELSE TO VIEW/ACCESS YOUR MEDICAL RECORDS**

**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 my medical record 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**

|  |  |
| --- | --- |
| Appointments booking | 🞏 |
| Prescription management | 🞏 |
| Accessing the medical record for (name of patient) | 🞏 |
| Communicating decisions made on behalf of (name of patient) | 🞏 |

**Section 3**

I/we…………………………………………………………………………….. (names of representatives) wish to have 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 understood the information agree that I will treat the patient information as confidential
 | 🞏 |
| I/we will be responsible for the security of the information that I/we see or download (online) | 🞏 |
| I/we will contact the practice as soon as possible if I/we suspect that there has been unauthorised access to the information | 🞏 |
| If the patient decides against this at any point I understand that this right will be revoked. | 🞏 |

|  |  |
| --- | --- |
| 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 |
| 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 | Method of verificationVouching 🞏Vouching with information in record 🞏 Photo ID and proof of residence 🞏 |
| Proxy access authorised by  | Date |
| Date account created  |
| Date passphrase sent  |
| Level of record access enabled  Prospective 🞏Retrospective 🞏 All 🞏Limited parts 🞏Contractual minimum 🞏 | Notes / comments on proxy access |