Patient Access Application Form – Proxy Access(Patient 16+)

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| --- | --- |
| **PATIENT DETAILS:**  | Date of birth |
| Surname | First name |
| AddressPostcode |
| Email address |
| Telephone number | Mobile number |
| **PROXY DETAILS:** |  |
| Surname | First name |
| Address | Postcode |
| Email address | Date of birth |
| Telephone number | Mobile number |

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

|  |  |
| --- | --- |
| 1. Booking appointments |  |
| 2. Requesting repeat prescriptions |  |
| 3. Accessing my medical record |  |

I wish my proxy to access my medical record online and both myself and my proxy understand

 and agree with each statement (tick)

Date

 **Signature of Patient**

pppppppppppppatientppatientSignature

|  |  |
| --- | --- |
| 1. I have read and understood the information leaflet provided by the practice |  |
| 2. I will be responsible for the security of the information that I see or download |  |
| 3. If I choose to share my information with anyone else, this is at my own risk |  |
| 4. If I suspect that my account has been accessed by someone without myagreement, I will contact the practice as soon as possible |  |
| 5. If I see information in my record that is not about me or is inaccurate, I willcontact the practice as soon as possible |  |
| 6. If I think that I may come under pressure to give access to someone elseunwillingly I will contact the practice as soon as possible. |  |

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| --- | --- |
| **Signature of Proxy**  | Date |

**For practice use only**

|  |  |  |
| --- | --- | --- |
| Patient Identity verified by  | Date | Method: (please tick) Vouching 🞏Vouching with information in record 🞏 Photo ID(please state type) 🞏 Proof of residence 🞏 |
| Proxy Identity verified by | Date  | Method: (please tick) Vouching 🞏Vouching with information in record 🞏 Photo ID(please state type) 🞏 Proof of residence 🞏 |
| Date account created |
| Date log in credentials sent/handed to patient |

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| --- | --- |
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**PLEASE NOW RETURN THE FORM TO RECEPTION**

|  |  |  |  |
| --- | --- | --- | --- |
| Scanned & sent for filing by | Name | Signature | Date |