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**Application For Proxy Access To Online Services**

**Consent to proxy access to GP online services (for parents, carers, etc.)**

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 (Patient to complete. NOT REQUIRED FOR CHILDREN UNDER 11 YEARS OF AGE)**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (**name of patient**), give permission for my GP practice to give the following person \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ proxy access to my medical records.

* 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 of patient | Date  |

**Section 2 (Representative / Proxy to complete)**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (**name of representative/proxy**) wish to have online access to the medical records of ­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (**name of patient**). I understand my responsibility for safeguarding sensitive medical information and I understand and agree with each of the following statements (please tick):

|  |  |
| --- | --- |
| 1. I have read and understood the information leaflet provided by the practice and agree that I will treat the patient information as confidential
 |  |
| 1. I will be responsible for the security of the information that I we see or download
 |  |
| 1. I will contact the practice as soon as possible if I suspect that the account has been accessed by someone without my agreement
 |  |
| 1. If I see information in the record that is not about the patient, or is inaccurate, I we will contact the practice as soon as possible. I will treat any information which is not about the patient as being strictly confidential
 |  |
| **Relationship to patient (*please circle below*)** |
| Carer | Friend | Family Member | Child | Mother | Father |

|  |  |
| --- | --- |
| Signature of representative / Proxy | Date  |

Please ensure you bring the following to the surgery with the completed Proxy Access form:

**Patient ID Required**

Two original forms of identity. One must be photo ID. **Birth certificate if under 12.**

**Representative/Proxy ID Required**

Two original forms of identity. One must be photo ID

**The Patient** (*This is the person whose records are being accessed)*

|  |  |
| --- | --- |
| Surname | Date of birth |
| First name |
| AddressPostcode |
| Email address *(must match patient records)* |
| Telephone number | Mobile Number |

**The representative / proxy**

*(This is the person seeking proxy access to the patient’s online records.)*

|  |
| --- |
| Surname |
| First name |
| AddressPostcode |
| Email *(must match online services account)* |
| Mobile number |
| Landline number |

**For practice use only: (check for patient and proxy requester)**

|  |  |
| --- | --- |
| **The patient’s NHS number** |  |
| **ID verified (initials)** | **Date** | **Method – patient**Personal vouching [ ] Vouching with information in record [ ] Two ID documents. One must be Photo ID – attach copies [ ] Under 12s birth certificate required [ ] |
| **ID verified (initials)** | **Date** | **Method – proxy requester** Personal vouching [ ] Vouching with information in record [ ] Two ID documents. One must be Photo ID – attach copies [ ] |
| **Proxy access authorised by (name)** | **Date** |
| **Proxy access activated by (name)** | **Date** |

|  |  |  |
| --- | --- | --- |
| Full Access | Partial Access | Other (*please state)* |

Patient Requesting *(please circle)*