**Consent to proxy access to GP online services**

**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. Proxy access application will not be accepted from any third party commercial company i.e. Insurance company or solicitors.

**Proxy Access:** Parents may request a proxy access to their children’s records; this will cease automatically when the child reaches the age of **11**. Any subsequent proxy access will need to be authorised by the patient subject to a Gillick competency test being completed at an appointment with a GP. Access will cease again at age 16.

**Section 1**

I,………………………………………………….. (Name of patient), give permission to my GP practice to give the following people ….………………………………………………………………..…………….. Proxy access to the online services 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.

I have read and understand the information leaflet provided by the practice

|  |  |
| --- | --- |
| Signature of patient | Date |

**Section 2**

|  |  |
| --- | --- |
| 1. Online appointments booking | o |
| 1. Online prescription management | o |
| 1. Full medical records | o |

**Section 3**

I/we…………………………………………………………………………….. (Names of representatives) wish to have online 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 have read and understood the information leaflet provided by the practice and agree that I will treat the patient information as confidential | o |
| 1. I/we will be responsible for the security of the information that I/we see or download | o |
| 1. I/we will contact the practice as soon as possible if I/we suspect that the account has been accessed by someone without my/our agreement | o |
| 1. If I/we 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 | o |

|  |  |
| --- | --- |
| Signature/s of representative/s | Date |

**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 |
| Address  Postcode | Address (tick if both same address o)  Postcode |
| Email | Email |
| Telephone | Telephone |
| Mobile | Mobile |

**Proxy Access:** Parents may request a proxy access to their children’s records; this will cease automatically when the child reaches the age of 11. Any subsequent proxy access will need to authorised by the patient subject to a competency test being completed.

**For practice use only**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| The patient’s NHS number | | The patient’s practice computer ID number | | |
| Identity verified by  (initials) | Date | Method of verification  Vouching o  Vouching with information in record o  Photo ID and proof of residence o | | |
| Proxy access authorised by | | | | Date |
| Date account created | | | | |
| Date passphrase sent | | | | |
| Level of record access enabled    Appointments, Summary Record & Repeat medication o  All o  Limited parts o | | | Notes / comments on proxy access | |