**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.

**Section 1 - Request**

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 – Access To Records**

|  |  |
| --- | --- |
| 1. Booking Appointments
 | 🞏 |
| 1. Requesting Repeat Medication
 | 🞏 |
| 1. Accessing the Medical Records
 | 🞏 |

**Section 3 - Declaration**

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
 | 🞏 |
| 1. I/we will be responsible for the security of the information that I/we see or download
 | 🞏 |
| 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
 | 🞏 |
| 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
 | 🞏 |

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

**Section 4 – 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 |

**Section 4 – 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 EMIS number |
| Identity verified by(initials) | Date | Method of verificationPhoto ID and proof of residence 🞏Vouching 🞏Proof of parental responsibility 🞏 |
| Proxy access authorised by  | Date |
| Date account created  |
| Date passphrase sent  |