

## 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.

### 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
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### Section 2

1. Online appointments booking	<input type="checkbox"/>
2. Online prescription management	<input type="checkbox"/>
3. Accessing the medical record for (name of patient)	<input type="checkbox"/>

### 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	<input type="checkbox"/>
2. I/we will be responsible for the security of the information that I/we see or download	<input type="checkbox"/>
3. 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	<input type="checkbox"/>
4. 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	<input type="checkbox"/>

Signature/s of representative/s	Date/s
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## 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	Address (tick if both same address <input type="checkbox"/> )
Postcode	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 verification Vouching <input type="checkbox"/> Vouching with information in record <input type="checkbox"/> Photo ID and proof of residence <input type="checkbox"/>	
Proxy access authorised by			Date
Date account created			
Date passphrase sent			
Level of record access enabled Prospective <input type="checkbox"/> Retrospective <input type="checkbox"/> All <input type="checkbox"/> Limited parts <input type="checkbox"/> Contractual minimum <input type="checkbox"/>		Notes / comments on proxy access	