

**Consent to proxy access to GP online services (over 16s only)**

**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 signed by the patient’s named GP.

I,……………………………………………………………. (name of patient), give permission to Park Practice to give the following people ….………………………………………………………………..……. proxy access to the online services as indicated below.

|  |  |
| --- | --- |
| Booking appointments |  |
| Requesting repeat prescriptions |  |
| Basic access to medical records |  |
| Access to detailed medical records (another form will need completing) |  |

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

I …………………………………………………………………………….. (name of representative) wish to have online access to the services ticked in the box above for ……………………………………………………. (name of patient).

I understand my responsibility for safeguarding sensitive medical information.

I understand and agree with each of the following statements (please tick):

|  |  |
| --- | --- |
| I have read and understood the information leaflet provided by the practice and agree that I will treat the patient information as confidential |  |
| I will be responsible for the security of the information that I see or download |  |
| I will contact the practice as soon as possible if I suspect that the account has been accessed by someone without the agreement of the patient |  |
| If I see information in the record that is not about the patient or is inaccurate, I will contact the practice as soon as possible. I will treat any information which is not about the patient as being strictly confidential. |  |

|  |  |
| --- | --- |
| Signature of representative | Date |

**The patient** (The person whose online records are to be accessed)

**The patient must produce their proof of photo ID (staff to verify below)**

|  |  |
| --- | --- |
| Surname | Date of birth |
| First name | |
| Address  Postcode | |
| Email address | |
| Telephone number | Mobile number |

**The representative** (The person seeking proxy access to the patient’s online services)

**The representative must produce their proof of photo ID (staff to verify below)**

Surname

First name Date of birth Address

Postcode

Email Telephone Mobile

**For practice use only**

|  |  |  |
| --- | --- | --- |
| Patient’s NHS number | Patient’s Emis ID number | |
| Patient identity verified by  (initials) | Date | Photo ID and proof of residence  Vouching with non-photo ID  Vouching with information in record |
| Representative identity verified by  (initials) | Date | Photo ID and proof of residence  Vouching with non-photo ID  Vouching with information in record |
| Proxy access authorised by | | Date |
| Date account created | | |
| Date passphrase sent | | |
| Level of record access enabled  Appt  Px  Summary  DCRA | | Notes / comments on proxy access |