Consent to Proxy Access to GP Online Services

Please 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**

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 understand and agree with each statement below: **Tick ✓** | |
| 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 |  |

**Section 2**

|  |  |
| --- | --- |
| Standard Access **Tick ✓** | |
| Online appointments booking |  |
| Online prescription management |  |
| Enhanced Access | |
| Accessing the medical record for (name of patient) |  |

**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:

|  |  |
| --- | --- |
| I/ we understand and agree with each statement below **Tick ✓** | |
| I/we have read and understood the information leaflet provided by the practice and agree that I will treat the patient information as confidential |  |
| I/we will be responsible for the security of the information that I/we see or download |  |
| 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 |  |
| 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 | |

**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  Postcode |
| Email | Email |
| Telephone | Telephone |
| Mobile | Mobile |

**For Reception Use**

|  |  |  |  |
| --- | --- | --- | --- |
| Identity verified by  (initials) | Date | Method of verification  Vouching 🞏  Vouching with information in record 🞏  Photo ID and proof of residence 🞏 | |
| The patient’s NHS number | | The patient’s EMIS number | |
| **For GP Use** | | |  |
| Proxy access authorised by | | | Date |
| **For Admin Use** | | | |
| Date access enabled | | | |
| Date activation letter sent | | | |
| Level of record access enabled  Standard Access □  Enhanced Access □ | | Notes / comments on proxy access | |