** Proxy Access to Health Records Request**

**For patients aged 16 and over only**

**In accordance with the UK General Data Protection Regulation (UK GDPR)**

**Guidance notes – please read before completing this form:**

Before you complete this form, please read the “**Proxy Access to GP Online Services’** leaflet provided to you by Reception.

Please complete this form and return it to the practice, along with two forms of identification one of which must be photographic.

**Section 1: Patient details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Surname** |  | **Former name** |  |
| **Forename** |  | **Title** |  |
| **Date of birth** |  | **Address:** |  |
| **Telephone number** |  | **Postcode:** |  |
| **NHS number (if known)** | **Hospital number (if known)** |
| **Email:** |  |

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 3.**

**Section 2: Proxy access online services available**

I consent to proxy access for the following online services (please tick all that apply):

|  |  |
| --- | --- |
| Booking appointments | 🞏 |
| Requesting repeat prescriptions | 🞏 |
| Access to my retrospective electronic medical records | 🞏 |
| Access to my prospective electronic medical records | 🞏 |

I understand and agree with each statement below:

|  |  |
| --- | --- |
| 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 | 🞏 |

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient signature** |  | **Date** |  |

**Section 3: Applicants Details**

I/We wish to have access to the health records on **behalf of** the above-named patient

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

(If more than one person is to be given access then please list the above details for each additional person on a separate sheet of paper)

**Section 4: Reason for access**

|  |  |
| --- | --- |
| I/We have been asked by the patient | 🞏 |
| I/We have been appointed by the Court to manage the patient’s affairs and attach a certified copy of the court order appointing me to do so(for example lasting power of attorney for health and welfare with the Office of the Public Guardian) | 🞏  |

**For access to deceased medical records, please complete the Access to Deceased Patient’s Health Record Information and Application Form 2023**

**Section 5: Proxy declaration**

I/We wish to access to the medical record online of the above patient and I/we understand and agree with each statement

|  |  |
| --- | --- |
| I/We have read and understood the information leaflet provided by the organisation and agree that I/we 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 organisation as soon as possible. I/we will treat any information which is not about the patient as being strictly confidential | 🞏 |

I declare that the information given by me is correct to the best of my knowledge and that I am entitled to apply for access to the health records referred to above under the terms of the **Data** Protection Act 2018.

***You are advised that the making of false or misleading statements in order to obtain personal information to which you are not entitled is a criminal offence which could lead to prosecution*.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Applicant (s) signature (s)** |  | **Date** |  |

**Section 7: Proof of identity**

Under the Data Protection Act 2018, you do not have to give a reason for applying for access to your own health records. However, all applicants will be asked to provide two forms of identification, one of which must be photographic identification before access can be set up.

**Please speak to reception if you are unable to provide this.**

**Additional Notes:**

Before returning this form, please ensure that you have:

* Signed and dated the form
* Are able to provide proof of your identity or alternatively confirmed your identity by a countersignature
* Enclosed documentation to support your request (if applicable)

Incomplete applications will be returned; therefore, please ensure you have the correct documentation before returning the form.

**For office use only:**

**Identification verification must be verified through 2 forms of ID**

* One of which must contain a photo e.g., passport, photo driving licence or bank statement.

Where this is not available, vouching by a member of staff or by confirmation of information in the records by one of the clinicians may be used.

If this is a proxy request, where patient has capacity, both patient and proxy should provide identification as above in person.

|  |  |
| --- | --- |
| **Request received** |  |
| **Patient identity verified by** |  | **Date** |  |
| **Method** | 🞏 Photo ID or proof of residence – Type ………………………………..🞏 Photo ID or proof of residence – Type ………………………………..🞏 Vouching – by whom ……………………………………………………🞏 Vouching with information in record – by whom …………………… |
| **Proxy identity verified by** |  | **Date** |  |
| **Method** | 🞏 Photo ID or proof of residence – Type ………………………………..🞏 Photo ID or proof of residence – Type ………………………………..🞏 Vouching – by whom ……………………………………………………🞏 Vouching with information in record – by whom …………………… |
| **Request reviewed by** |  |
| **Proxy access authorised by** |  | **Proxy access request refused by** |  |
| **Proxy access coded in notes** | 🞏 Yes |
| **Level of access enabled** | □ All | □Prospective | □ Retrospective | □ Limited parts |
| **Date account created** |  | **Date password sent** |  |
| **Date online proxy access activated** |  |
| **Notes for proxy access*****(If any request is refused, discuss with the organisation’s DPO before informing patient/applicant*** |  |