**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 or the patient is a child under eleven, section 1 of this form may be omitted.

**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. **Dinnington Group Practice does not offer Proxy access for children between the ages of 11 and 16.**

**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 |

**Section 2**

|  |  |
| --- | --- |
| 1. Online appointments booking | 🞏 |
| 1. Online prescription management | 🞏 |
| 1. Access to the detailed coded medical record for   (name of patient) | 🞏 |
| 1. Access to the Full medical record from the date of application | 🞏 |

**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 | 🞏 |
| 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 |

**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 (tick if both same address 🞏)  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  (Name) | Date | Method of verification Vouching 🞏  Vouching with information in record 🞏  Photo ID 🞏  Proof of residence 🞏  Birth Certificate 🞏 | |
| Proxy access authorised by | | | Date |
| Date account created | | | |
| Date Account Denied | | Notes / comments on proxy access | |