# CENTRAL SURGERY

**Consent to proxy access to GP online services**

Go to Section 2 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. In all other cases, complete Section 1.

**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 |  |
| 2. Online prescription management |  |
| 3. Accessing my full medical records |  |

**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    1. 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 |  |
| 1. I/we consent for the Practice to check my association with the patient |  |

|  |  |
| --- | --- |
| Signature/s of representative/s | Date/s |

**Patient details**

|  |  |
| --- | --- |
| 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. If more representatives, please add them onto a separate sheet)

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

**THIS PAGE IS FOR PRACTICE USE ONLY**

**Proxy access to online patient record for an adult patient**

|  |  |
| --- | --- |
| Method of Verification: photo ID and proof of address   vouching (personal)   vouching by information from record  | |
| **Patient and proxy identities verified by** *(print)* | *(sign)* |
| **Application and patient record reviewed by (print)** | *(sign)* |
| **Application outcome** granted   declined  | **Date** |
| **Date account set up or enhanced access enabled**  **(if approved)** |  |
| |  | | --- | | **Notes/explanation** *(this should include any reason for declining access, which may be shared with the patient)* | | | |