**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 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 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. Accessing the medical record for (name of patient)
 |  |
| 3.1 Access to records from now | 🞏 |
| 3.2 Access to records from / / (Please specify reason below) | 🞏 |
| 3.3 Access to full medical records (Please specify reason below) | 🞏 |

Reason records access required.

|  |
| --- |
|  |

**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 |

**Section 4**

**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 |
| AddressPostcode  | Address (tick if both same address 🞏)Postcode |
| Email | Email |
| Telephone | Telephone |
| Mobile | Mobile |

**For practice use only**

|  |  |
| --- | --- |
| The patient’s NHS number |  |
| Identity verified by(initials) | Date | Method of verificationVouching 🞏Vouching with information in record 🞏 Photo ID and proof of residence 🞏 |
| Proxy access authorised by  | Date |
| Date account created  |
| Date passphrase sent  |
| Level of record access approved | GP Signature | Notes / comments on proxy access |
| Appointments 🞏 |  |
| Medication 🞏 |  |
| Prospective 🞏 | After the later of registration or 31/10/24 | Reason access denied |
| Retrospective 🞏  | Specify date / / |
| All 🞏 | Full records |