

**CONSENT TO PROXY ACCESS TO GP ONLINE SERVICES (including online medical record)**

Proxy access is access to a GP online account authorised by the patient for a second person to access their GP online account. Consent must be given by the patient (all patients aged 11 and above). In the event that a patient does not have capacity to consent to proxy access and proxy access is considered by the practice to be in the patient's best interests Section 1 of this form may be omitted.

**SECTION 1 – PATIENTS AGED 11 YEARS OLD AND ABOVE AND HAVE CAPACITY TO GIVE CONSENT**

**PATIENT DETAILS:**

<b>NAME:</b>
<b>DATE OF BIRTH:</b>
<b>ADDRESS:</b>
<b>EMAIL ADDRESS:</b>
<b>CONTACT NUMBER:</b>

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:

Names of representative(s).....  
.....

I reserve the right to reverse my 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 – PROXY ACCESS TO BE GIVEN**

<b>1. Online appointment booking</b>	
<b>2. Online prescription management</b>	
<b>3. Accessing the medical record of (name of patient)</b>	

*Continued overleaf*

### SECTION 3 – REPRESENTATIVES DETAILS

*For completion by all representatives to be given proxy access, **including** parents of children aged under 11 and for representatives of patients without mental capacity.*

<b>REPRESENTATIVE 1</b>	<b>REPRESENTATIVE 2</b>
<b>Name:</b>	<b>Name:</b>
<b>Date of Birth:</b>	<b>Date of Birth:</b>
<b>Are you registered at the practice Yes/No</b>	<b>Are you registered at the practice Yes/No</b>
<b>Relationship to patient:</b>	<b>Relationship to patient:</b>
<b>Contact Number:</b>	<b>Contact Number:</b>

I/we (names of representatives).....

Wish to have online access to the services ticked in Section 2 above for: Name of patient).....

.....I/we understand my/our responsibility for the safeguarding of sensitive medical information and I/we understand and agree with each of the following statements:

1. I/we have read and understood the patient 'Things to Consider' leaflet provided by the practice and agree that I will treat the patient information as confidential	
2. I/we will be responsible for the security of the information that I/we see or download	
3. 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	
4. 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	
<b>STATEMENTS BELOW FOR PARENTS OF CHILDREN AGED UNDER 11 AT TIME OF APPLICATION</b>	
1. I/we confirm that we have parental responsibility as per the child's birth certificate having been identified as the biological parents or formal adoption has taken place. I/we understand that parental responsibility is not lost on divorce and that where more than one parent has parental responsibility each may independently exercise their right of access.	
2. I/we understand that parental proxy access (only applicable for children aged under 11) will be automatically switched off when the child reaches their 11 <sup>th</sup> birthday and that the practice will contact I/us prior to the switching off date for us to discuss with our child if proxy access is consented to (child will need to complete the consent form). Children aged under 13 must not be given control of an internet service such as GP online services.	
3. I/we understand that parental proxy access for children aged between 11 and 16 will be regularly reviewed	
4. I/we understand that on a child reaching their 16 <sup>th</sup> birthday parental proxy access no longer applies	

**Signature(s)of representatives:**.....

.....**Date:**.....

**PRACTICE USE ONLY – PROXY ACCESS CONSENT FORM**

<b>Patient's NHS Number:</b>	
<b>Method of Patient Verification</b>  Vouching <input type="checkbox"/>  Vouching with information in record <input type="checkbox"/>  Photo ID and proof of residence (copies not needed) <input type="checkbox"/>	<b>Representatives Method of Verification:</b>  Vouching <input type="checkbox"/>  Vouching with information in record <input type="checkbox"/>  Photo ID (copies not needed) <input type="checkbox"/>
<b>Verified by (Staff Initials)</b>	<b>Date of Verification:</b>
<b>Proxy Access Authorised By:</b>	<b>Date:</b>
<b>Notes/Comments on Proxy Access:</b>	