**Farley Road Medical Practice**

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

**Note:** If the patient does not have capacity 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 signed by the patient’s names GP.

I,…………………………………………….(name of patient), give permission to Farley Road Medical Practice to give the following people……………………………………………………………proxy access to the online services as indicated below.

| Booking Appointments |  |
| --- | --- |
| Requesting Repeat Prescriptions |  |
| Access to part of my medical record as currently available |  |

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 |
| --- | --- |

I………………………………………………..(name of representative) wish to have online access to the services ticked in the box above for…………………………………….(name of patient).

I understand my responsibility for safeguarding sensitive medical information.

I understand and agree with each of the following statements:

| I have read and understood the information leaflet provided by the practice and agree that I will treat the patient information as confidential |  |
| --- | --- |
| I will be responsible for the security of the information that I see or download |  |
| I will contact the practice as soon as possible if I suspect that the account has been accessed by someone without the agreement of the patient |  |
| If I see information in the record that is not about the patient, or is inaccurate, I will contact the practice as soon as possible. I will treat any information which is not about the patient as being strictly confidential. |  |

| Signature of representative | Date |
| --- | --- |

**The Patient** (The person whose online records are to be accessed)

| Surname | Date of Birth |
| --- | --- |
| First Name | |
| Address | |
| Email Address | |
| Telephone Number | Mobile Number |

**The Representative** (The person seeking proxy access to the patient’s online services)

The Representative must produce their proof of photo ID and if registering on behalf of a child their child’s birth certificate or red child health book.

| Surname |
| --- |
| First Name |
| Date of Birth |
| Address  Postcode |
| Email |
| Telephone |
| Mobile |

**FOR PRACTICE USE ONLY**

| Patient’s NHS Number | | Patient’s Emis ID Number |
| --- | --- | --- |
| Identity verified by (initials) | Date | Photo ID and proof of residence  Vouching with non photo ID  Vouching with information in record |
| Proxy access authorised by Date | | |
| Date account created | | |
| Date passphrase sent | | |
| Level of record access enabled  Appointments, prescription and summary  Detailed Coded Record | | Notes/Comments on proxy access |