**THE OLD COURTHOUSE SURGERY**

**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 entitled \*\* ‘What you need to know about your GP online records’

|  |  |
| --- | --- |
| Signature of patient | Date |

**Section 2**

|  |  |
| --- | --- |
| 1. Online appointments booking
 | 🞏 |
| 1. Online prescription management
 | 🞏 |
| 1. Limited access to parts of the medical record for (name of patient)
 | 🞏 |

**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/ | 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 |
| AddressPostcode  | 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(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 enabled  Contractual minimum √Other…………………… | Notes / comments on proxy access |

Form to be returned to the surgery in person along with proof of photo ID for the patient and the representative/s.

Please ensure that you have read the proxy access leaflet on our website. A copy can be obtained from reception.