Consent to proxy access to GP online services for children under 16 years

Proxy access is when a competent patient can choose and consent to allow another representative access to their online services, this may be relatives or carers. Proxy access applications will not be accepted from any third party commercial company i.e. Insurance company or solicitors.

Note: If the 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 interest section 1 of this form may be omitted.

********* PLEASE PROVIDE PROOF OF PARENTAL RESPONSIBILITY SUCH AS A BIRTH CERTIFICATE OR A LEGAL DOCUMENT **********

For children aged 13- under 16 years online access is dependent upon a Gillick Competency Assessment, this will be carried out by a clinician. If the child is deemed to be fully competent then they must provide consent for a parent to have access to any online services. Where deemed to be not competent then access will be authorised, this can be reviewed at a later date to determine if child competency has changed.

Once a child reaches the age of 13, proxy access will be revoked. Any subsequent proxy access will need to re requested and authorised by the patient/child subject to a Gillick Competency Assessment, unless the child has previously been assessed and already deemed to be competent.

The patient (This is the person whose records are being accessed)

First name	Date of birth
Surname	
Address Postcode	
Email address	
Telephone number	Mobile number

The representatives (These are the people seeking proxy access to the child's online account)

Surname	Surname
First name	First name
Date of birth	Date of birth
Address Postcode	Address (tick if both same address ☐) Postcode
Email	Email
Telephone	Telephone
Mobile	Mobile

SECTION 1 - to be completed by parent/guardian for patient under 13 years of age.

I/ **we** wish to have online access to the services detailed below **in section 3** for the patient named above.

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

I/**we** agree that I/**we** will treat the patient information as confidential	☐
I/**we** will be responsible for the security of the information that I/we see or download	☐
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	☐
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/**we** will treat any information which is not about the patient as being strictly confidential	☐

Signature/**s** of representative/**s**	Date

SECTION 2 - to be completed by patient aged 13 – under 16 years of age.

I…….. (Name of patient), give permission to my GP practice to give the named representative(s) proxy access to online services as indicated below **in section 3**

I reserve the right to reverse any decision I make in granting proxy access at any time.

I understand that by allowing someone else to have access to my health record, this will include visibility to any sensitive or third party information which may be held within my record.

Signature of patient	Date

SECTION 3 – access to be given:

1. **Online appointments booking** ☐
2. **Online prescription management** ☐
3. **Summary record access** ☐

For practice use only

Method of verification

Birth certificate/legal document seen (mandatory) ☐

Name(s) of person(s) with parental responsibility:

……

Two forms of documentation including Photo ID obtained from representative ☐

Please state what forms of ID have been presented:

……..

……..

Vouching personal (know the representative by sight) ☐

Vouching with information in record (only if registered at this practice) ☐

Security information obtained:

1) ……..

2) ……..

3) ……..

Identity verified by (staff name)	Date