Consent to proxy access to GP online services – for patients 16 years and over

Proxy access is when a competent patient can choose and consent to allow a 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.

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 patient's online records)

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 the patient

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 2 – to be completed by the representative/s

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 3 – access to be given:

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

For practice use only

Method of verification

Two forms of documentation including Photo ID obtained from **patient** ☐

Please state what forms of ID have been presented:

……..

Two forms of documentation including Photo ID obtained from **representative(s)** ☐

Please state what forms of ID have been presented:

……..

Vouching personal (know the patient by sight) ☐

Vouching with information in record ☐

Security information obtained:

1) ……..
2) ……..
3) ……..

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