**Consent to proxy access to GP online services, appointment booking, repeat prescription.**

**The patient**

(This is the person whose records are being accessed)

|  |  |
| --- | --- |
| NHS No: | Date of Birth: |
| Surname: |
| First name: |
| Address: Postcode:  |
| Telephone number: | Mobile number: |

**The representatives**

(These are the people seeking proxy access to the patient’s appointments or repeat prescription.)

|  |  |
| --- | --- |
| Relationship to patient: |  |
| NHS No: | NHS No: |
| Surname: | Surname: |
| First name: | First name: |
| Date of birth: | Date of birth: |
| Address:Postcode: | Address: (tick if both same address 🞏)Postcode: |
| Telephone: | Telephone: |
| Mobile: | Mobile: |

Please give my parent/carer access to the following online services (Please tick all that apply)

**Section 2**

|  |  |
| --- | --- |
| 1. Online appointments booking
 | 🞏 |
| 1. Online prescription management
 | 🞏 |

|  |  |
| --- | --- |
| 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
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| 1. I/we will be responsible for the security of the information that I/we see or download
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| 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
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| 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
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|  |  |
| --- | --- |
| Signature/s of representative/s | Date/s |

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 |

**For practice use only**

|  |  |
| --- | --- |
| The patient’s name: | The representatives name: |
| Identity verified for patient 🞏  | Identity verified for representative 🞏 |
| Method of verificationVouching 🞏Vouching with information in record 🞏 Passport 🞏 Driving licence 🞏 other Photo ID 🞏  and proof of residence 🞏 | Method of verificationVouching 🞏Vouching with information in record 🞏 Passport 🞏 Driving licence 🞏 other Photo ID 🞏 and proof of residence 🞏 |
| Identity verified by: | Date: |
| Proxy access authorised by  | Date |
| Date account created  |
| Date passphrase sent  |
| Level of record access enabled  Prospective 🞏Retrospective 🞏 All 🞏Limited parts 🞏Contractual minimum 🞏 | Notes / comments on proxy access |