**Bewicke Medical Centre**

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

**Definition: “Proxy access- a person that is authorised to act on behalf of another or the authority to represent someone else”**

**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.**

**Proxy access application will not be accepted from any third party commercial company i.e. Insurance company or solicitors**.

**The practice may refuse or withdraw proxy access, if they judge that it is the patient’s best interest to do so.**

**Proxy Access:** A person with parental responsibility may request a proxy access to their children’s records; this will cease automatically when the child reaches the age of **11**. Any subsequent proxy access will need to authorise by the patient subject to a Gillick competency test being completed.

**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

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

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

**Section 2**

|  |  |
| --- | --- |
| 1. Online appointments booking | 🞏 |
| 1. Online prescription management | 🞏 |
| 1. Accessing medical record | 🞏 |

**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/s | Date/s |

**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 |
| Address  Postcode | Address (tick if both same address 🞏)  Postcode |
| Email | Email |
| Telephone | Telephone |
| Mobile | Mobile |

**Proxy Access:** Parents may request a proxy access to their children’s records; this will cease automatically when the child reaches the age of 11. Any subsequent proxy access will need to authorised by the patient subject to a competency test being completed.

**For practice use only**

|  |  |  |  |
| --- | --- | --- | --- |
| The patient’s NHS number | | Method of verification  Vouching 🞏  Vouching with information in record 🞏  Photo ID and proof of residence 🞏 | |
| Identity verified by  (initials) | Date | Level of record access enabled  Proxy access authorised by | |
| Date Account created  Date passphrase given | | | Notes |