**THE CROWN MEDICAL CENTRE**

**Proxy access consent for GP online Services**

**Please note:** If the patient does not have capacity to consent to grant proxy access and proxy access is conside4red by the practice to be in the patients best interest, section 1 of this form may be omitted.

**Section 1:** (to be completed by patient)

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name of patient), give permission to my GP

practice to give the following person \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 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 understood the information leaflet provided by the practice.

|  |  |
| --- | --- |
| **Signature of patient:** | **Date:** |

**Section 2:**

|  |  |
| --- | --- |
| 1. Booking appointments |  |
| 1. Requesting repeat prescriptions |  |
| 1. Online access to medical record |  |

**Section 3:** (to be completed by representative)

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ wish to have online

access to the services ticked in the above box in section 2 for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name of patient).

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

|  |  |
| --- | --- |
| 1. I have read and understood the information leaflet provided by the practice and agree that I will treat the patients information as confidential |  |
| 1. I will be responsible for the security of the information that I see or download |  |
| 1. I will contact the practice as soon as possible if I suspect that the account has been accessed by someone without my agreement |  |
| 4. If I see information in the record that is not about the patient, or is inaccurate I will contact the surgery in writing as soon as possible. I will treat any information which is not about the patient as being strictly confidential |  |

|  |  |
| --- | --- |
| **Signature of representative:** | **Date:** |

**THE PATIENT –** This is the person whose records are being accessed

|  |  |
| --- | --- |
| **Surname:** | **Forename:** |
| **Date of birth:** | |
| **Address:**  **Postcode:** | |
| **Email address:** | |
| **Telephone number:** | **Mobile number:** |
| **Usual GP:** | |

**THE REPRESENTATIVES** – This is the person who is seeking proxy access to the patient’s online appointments, medications or online medical record.

|  |  |
| --- | --- |
| **Surname:** | **Forename:** |
| **Date of birth:** | |
| **Address:**  **Postcode:** | |
| **Email address:** | |
| **Telephone number:** | **Mobile number:** |

# For practice use only

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Patient NHS number | | | Practice computer ID number | |
| Identity verified by (initials) | Date | | Method  Photo ID and proof of residence  | |
| Authorised by (GP for Medical Record Access) | | | | Date |
| Date Notes Reviewed by GP | | | | |
| Date Form Scanned onto notes | | | | |
| Date account created and enabled appointments  medication medical record | | | | |
| Level of record access enabled  All   Prospective  Retrospective   Detailed coded record   Limited parts  | | Notes / explanation | | |