

"Empowering our community to achieve greater health and wellbeing"

2 Nimrod Street, Aylesbury, HP18 1BB, Tel: 01296-310940, [www.berrycrofthealth.co.uk](http://www.berrycrofthealth.co.uk)

**Application for proxy access to online services**

Consent to proxy access to GP online services (for parents, carers, etc)

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.

**Section 1** (Patient to complete. NOT REQUIRED FOR UNDER 11s)

I, , 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.

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

**Section 2 (please tick access to be given)**

|  |  |
| --- | --- |
| 1. Appointment booking |  |
| 2. Demographics (Name, Address, DOB, NHS number) |  |
| 3. Prescription management |  |

If you require historic access to records, please email the surgery with your request, the GP will review this access will be granted at their discretion.

The Patient (this is the person whose records are being accessed)

|  |  |
| --- | --- |
| First name: | Date of birth: |
| Surname: | |
| Address:    Postcode: | |
| Email Address: | |
| Home Telephone No: | Mobile Number: |

The Representative/Proxy (These are the people seeking proxy access to the patient’s online records, appointments or repeat prescriptions)

|  |
| --- |
| First name: |
| Surname: |
| Date of birth: |
| Address:          Postcode: |
| Email: |
| Home telephone: |
| Mobile: |
| Relationship to Patient: |
| Are you registered at the Surgery (delete as appropriate) YES/NO |

I\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (names of representative) wish to have online access to the services ticked in the box above in section 2 for\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

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

|  |  |
| --- | --- |
| 1. I will be responsible for the security of the information that I see or download | ☐ |
| 2. I will contact the practice as soon as possible if I suspect that the account has been accessed by someone without my agreement | ☐ |
| 3. If I see information in the record that is not about the patient, or is inaccurate, I will contact the practice as soon as possible. I will treat any information which is not about the patient as being strictly confidential | ☐ |
| 4.If I have access to my child’s record, I understand that this will be switched firstly on their 11th birthday; and then, if applicable on their 16th birthday | ☐ |

|  |  |
| --- | --- |
| Signature/s of representative/s | Date |

**Patient ID required =** Photo ID or birth certificate if no photo id available

**Representative/Proxy ID required =** Photo ID i.e. Passport, Drivers License, Biometric resident card, Bus pass.

For practice use only only

|  |  |  |  |
| --- | --- | --- | --- |
| Patient’s NHS Number: |  | | |
| Identity verified by:  (initials) | Date: | Patient    ☐ Vouching (Reg’d/usual Dr only)    ☐ Vouching with information in record (Reg’d/usual Dr only)    ☐ Photo ID (rec staff to attach copies)    ☐ Under 16s birth certificate if no photo ID (rec staff to attach copies) | |
| Proxy requester    ☐ Vouching (Reg’d/usual Dr only)    ☐ Vouching with information in record (Reg’d/usual Dr only)    ☐ Photo ID (rec staff to attach copies) | |
| Proxy access authorised by (Clinician only)      Print: Signature: | | | Date: |
| Notes / comments on proxy access | | | | |