



Consent to proxy access to GP online services

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

I, (name of patient), give permission to my GP practice to give the named person below 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 (Please note if between 11-16years, signature must be witness by a member of Longfield MC staff. | Date |
|--|------|

Section 2

| | |
|-----------------------------------|--------------------------|
| 1. Online appointments booking | <input type="checkbox"/> |
| 2. Online prescription management | <input type="checkbox"/> |

Section 3

I (name of representative) wish to have online access to the services ticked in the box above 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 patient information as confidential | <input type="checkbox"/> |
| 2. I will be responsible for the security of the information that I/we see or download | <input type="checkbox"/> |
| 3. I will contact the practice as soon as possible if I suspect that the account has been accessed by someone without my/our agreement | <input type="checkbox"/> |
| 4. 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 | <input type="checkbox"/> |

| | |
|-----------------------------|------|
| Signature of representative | Date |
|-----------------------------|------|

The patient

(This is the person whose records are being accessed)

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

The representative

(This are the people seeking proxy access to the patient's online records, appointments or repeat prescription.)

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

For practice use only

| | | | |
|----------------------------------|------|---|--|
| The patient's NHS number | | The patient's practice computer ID number | |
| Identity verified by (initials) | Date | Method of verification Vouching <input type="checkbox"/> Vouching with information in record <input type="checkbox"/> Photo ID and proof of residence <input type="checkbox"/> | |
| Proxy access authorised by | | Date | |
| Date account created | | | |
| Notes / comments on proxy access | | | |