



## 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 in Section 3 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 within this form.

Patient Signature:	
Date:	

### Section 2

Please tick all that apply:

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

### Section 3

I ..... (name of the 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)

Title (please tick one):	Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/> Other:
Forename(s):	
Surname:	
Date of Birth:	
Current Address: (including postcode)	
Telephone/Mobile No:	
Email:	

## **The representative**

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

Please tick if you are you a patient at Longfield Medical Centre.	<input type="checkbox"/>
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Title (please tick one):	Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/> Other:
Forename(s):	
Surname:	
Date of Birth:	
Current Address: (including postcode)	
Telephone/Mobile No:	
Email:	
Relationship to Patient:	

## **For practice use only**

Date:..... ID Checked By: .....

Patients ID seen & Type:  .....

Representatives ID seen & Type:  .....

Date account created	
Notes or comments on proxy access:	