Application Form for Proxy Online Access

**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 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 understand the information leaflet provided by the practice

Signature of patient …………………………………………………… Date ……………………

**Section 2**

**I wish to have access to the following online services (please tick all that apply)**

1. Requesting repeat prescriptions

2a. Accessing the (future) medical record for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name of patient)

2b. Accessing the (past) medical record for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name of patient) to view past content from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (enter date)

**Please note:** There may be a significant delay in processing your application if you wish to request this (3b) level of access. This is to allow time for a necessary review of your record. Exclusions apply.

**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 by signing below I am confirming that I understand and agree with the following statements**

1. I understand that I can request information and educational resources from my GP Practice
2. I will be responsible for the security of the information that I see or download
3. 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 practice as soon as possible. I will treat any information which is not about the patient as being strictly confidential
5. If I think that I may come under pressure to give access to someone else unwillingly I will contact the practice as soon as possible

Signature of patient …………………………………………………… Date ……………………

**Section 4**

|  |  |
| --- | --- |
| **The Patient** (This is the person whose records are being accessed) | |
| Surname | DOB |
| First name | NHS no. |
| Address  Postcode | |
| Tel | Mobile |
| Email address | |
| **The Representative** (This is the person seeking proxy access to the patient’s online records, appointments or repeat prescription.) | |
| Surname | DOB |
| First name | NHS no. |
| Relation to patient | |
| Address  Postcode | |
| Tel | Mobile |
| Email address | |

**For Practice Use Only**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| The patient’s NHS number | | | | | |
| Identity verified by  Date | Method of verification  Vouching  Vouching with information in record  Photo ID and proof of residence | | | |  |
| Documentary evidence provided | | | | | |
| Proxy access authorised by | | | | Date | |
| Date account created | | | | | |
| Date login credentials emailed/given | | | | | |
| Level of record access enabled  Prescriptions  Full prospective record  Full retrospective record from date: \_\_\_\_\_\_\_\_\_\_\_  Detailed coded record from date: \_\_\_\_\_\_\_\_\_\_\_\_ | |  | Notes/explanation | | |
| Date clinical assurance completed | | Assured by (initials) | | | |
| Reason for refusal if record access is refused after clinical assurance | | | | | |

**Once the form has been completed it should be scanned and filed to the patient’s record**