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**Consent to proxy access to GP online services**

**Note**: If the patient does not have capacity to consent to grant proxy access please acquire Power of Attorney for Welfare or a Court Of Protection Certificate as the surgery cannot grant access without this if the patient is unable to consent. If patient cannot consent and you attach either of these forms please go directly to section 3.

**Section 1**

I,………………………………………………….. (name of patient), 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.

I have read and understand the information leaflet provided by the practice

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

**Section 2**

|  |  |
| --- | --- |
| 1. Online appointments booking
 | 🞏 |
| 1. Online prescription management
 | 🞏 |
| 1. Accessing the medical record for (name of patient)
 | 🞏 |

**Section 3**

I/we…………………………………………………………………………….. (names of representatives) wish to have online access to the services ticked in the box above in section 2

for ……………………………………….……… (name of patient).

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

|  |  |
| --- | --- |
| 1. I/we have one of the following forms as patient does not have capacity to consent:

Power of Attorney to Welfare – Court of protection certificate which is attached | 🞏 |
| 1. I/we have read and understood the information leaflet provided by the practice and agree that I will treat the patient information as confidential
 | 🞏 |
| 1. I/we will be responsible for the security of the information that I/we see or download
 | 🞏 |
| 1. I/we will contact the practice as soon as possible if I/we suspect that the account has been accessed by someone without my/our agreement
 | 🞏 |
| 1. If I/we see information in the record that is not about the patient, or is inaccurate, I/we will contact the practice as soon as possible. I will treat any information which is not about the patient as being strictly confidential
 | 🞏 |

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

**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 representatives**

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

|  |  |
| --- | --- |
| Surname | Surname |
| First name | First name |
| Date of birth | Date of birth |
| AddressPostcode  | Address (tick if both same address 🞏)Postcode |
| Email | Email |
| Telephone | Telephone |
| Mobile | Mobile |

**For practice use only**

|  |  |
| --- | --- |
| The patient’s NHS number |  |
| Identity verified by(initials) | Date | Method of verification Vouching 🞏Vouching with information in record 🞏 Photo ID and proof of residence 🞏 |
| Proxy access authorised by  | Date |
| Date account created  |
| Date passphrase sent  |
| Level of record access enabled  Full Medical Record 🞏 Limited parts 🞏Detailed Coded Record 🞏 | Notes / comments on proxy access |