**T R I N I T Y M E D I C A L C E N T R E**

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 signed by the patient’s named GP.

**Section 1**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name of patient), give permission to Stonefield Surgery to give the following person/people: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Proxy access to online services as indicated below in section 2.

**Section 2**

|  |  |
| --- | --- |
| Booking appointments: | Yes / No |
| Requesting repeat Prescriptions: | Yes / No |
| Access to parts of my medical record as currently available: | Yes / No |

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 understood the information leaflet provided by the practice.

**Signature of Patient**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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.

I understand and agree with each of the following statements: -

* I have read and understood the information leaflet provided by the practice and agree that I will treat the patient information as confidential.
* I will be responsible for the security of the information that I see or download.
* I will contact the practice as soon as possible if I suspect that the account has been accessed by someone without the agreement of the patient.
* 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.

Signature of Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The Patient** (the person whose online records are to be accessed)

|  |
| --- |
| Surname: Date of Birth: |
| First Name: |
| Address: |
| Email address: |
| Telephone No: Mobile No: |

**The Representative** (the person seeking proxy access to the patient’s online services)

|  |
| --- |
| Surname: Date of Birth: |
| First Name: |
| Address: |
| Email address: |
| Telephone No: Mobile No: |

***For Practice use only:***

|  |  |  |
| --- | --- | --- |
| ***Patient NHS No:*** | | ***Practice Computer ID No:*** |
| ***Identity verified by (initials)*** | ***Date*** | ***Method***  ***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***  ***Detailed coded***  ***Record?***  ***Limited Parts?*** | | ***Notes / Explanations*** |