**Dr Baxter and Partners**

**Application for proxy access to GP Online Services**

**(Children aged 0-11 or Patients aged 16+ and have given signed consent)**

**Patient Details:**

|  |  |
| --- | --- |
| **SURNAME:** | **DATE OF BIRTH:** |
| **FIRST NAME:** |
| **ADDRESS:** |
|  |
| **EMAIL ADDRESS:** |
| **TELEPHONE NUMBER: MOBILE NUMBER:**  |

**Proxy Details:**

|  |
| --- |
| **RELATIONSHIP TO PATIENT:**  |
| **SURNAME:**  | **DATE OF BIRTH:** |
| **FIRST NAME:** |
| **ADDRESS:** |
|  |
| **EMAIL ADDRESS:** |
| **TELEPHONE NUMBER: MOBILE NUMBER:**  |
| **DO YOU HOLD YOUR OWN ONLINE SERVICES ACCOUNT AT THE SURGERY?**  | **Yes** | **No**  |

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

|  |  |
| --- | --- |
| 1. **BOOKING AND CANCELLING APPOINTMENTS**
 |  |
| 1. **REQUESTING REPEAT PRESCRIPTIONS**
 |  |
| 1. **QUESTIONAIRES**
 |  |
| 1. **SUMMARY CARE RECORD**
 |  |
| 1. **LIMITED ACCESS TO PARTS OF THE MEDICAL RECORD – CODED DATA ONLY**
 |  |
| 1. **FULL MEDICAL RECORD – AVAILABLE FROM NOVEMBER 2022**
 |  |

***I wish to access my medical record online and understand and agree with each statement (tick)***

|  |  |
| --- | --- |
| 1. **I HAVE READ AND UNDERSTOOD THE INFORMATION LEAFLET PROVIDED**

**BY THE PRACTICE** |  |
| 1. **I WILL BE REPONSIBLE FOR THE SECURITY OF THE INFORMATION THAT I SEE OR DOWNLOAD**
 |  |
| 1. **IF I CHOOSE TO SHARE MY INFORMATION WITH ANYONE ELSE, THIS IS AT MY OWN RISK**
 |  |
| 1. **I WILL CONTACT THE PRACTICE AS SOON AS POSSIBLE IF I SUSPECT THAT MY ACCOUNT HAS BEEN ACCESSED BY SOMEONE WITHOUT MY AGREEMENT**
 |  |
| 1. **IF I SEE INFORMATION IN MY RECORD THAT IS NOT ABOUT ME OR IS INACCURATE, I WILL CONTACT THE PRACTICE AS SOON AS POSSIBLE**
 |  |

**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 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 |

Before providing proxy access login credentials to anyone, the practice team must:

1. Satisfy themselves that they have the explicit consent from the patient to provide GP Online Services to the proxy, or where the patient is not able to consent, another legal justification for providing proxy access

2. Establish the level of access that the patient wants the proxy to have, where your system allows a choice.

3. Seek assurance that the patient is not being coerced to agree to proxy access unwillingly. Consider withholding providing proxy access until the suspicions are investigated and outcome known.

4. Obtain a completed proxy access consent form has been signed by the patient when it is appropriate.

5. Obtain authorisation from a senior clinician for the proxy to have access to the record

6. Ensure that the proxy understands how to maintain the privacy and security of the patient’s records and how and when to discuss with the practice anything in the record that worries them

7. Verify the identity of the individual

***FOR PRACTICE USE ONLY:***

|  |  |
| --- | --- |
| **Patient NHS No.**  |  |
| **Identity Verified By: Date:** |  |
| **Method: Vouching Vouching with Information in Record Photo ID and Proof of Residence** | **(circle)** |
| **Authorised By: Date:** |  |
| **Level of Record Access Enabled - Contractual Minimum C:\Users\Sharon.Barnes\AppData\Local\Microsoft\Windows\INetCache\IE\PUT3K7ZD\tick-305245_1280[1].png Other:**  |  |
| **Notes/Explanation:** |  |