

AshLea Medical Practice

Consent to proxy access to GP online services



Proxy Access: Proxy or third party access can be applied for with patient consent on this application form. Online access may be granted for parents, carers or legal guardians to access children's records under the age of 13. Children aged 13 and over would be required to consent to proxy access to their records under General Data Protection Regulations.

If the patient does not have capacity to consent to 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. Proxy access application will not be accepted from any third party commercial company i.e. Insurance company or solicitors.

Section 1 – For Patient

I,..... (Name of patient), give permission to my GP practice to give the following people:

..... (Third Party name)
 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 - For Patient

Please indicate in the boxes by ticking which items are being applied for in this section:

Online appointments booking	<input type="checkbox"/>
Online prescription management	<input type="checkbox"/>
Full medical records	<input type="checkbox"/>

Section 3 – For Third Party/Carer

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:

I/We 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"/>
I/We will be responsible for the security of the information that I/we see or download	<input type="checkbox"/>
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	<input type="checkbox"/>
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	<input type="checkbox"/>

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
Address	Address (tick if both same address <input type="checkbox"/>)
Postcode	Postcode
Email*	Email
Telephone	Telephone
Mobile	Mobile

ID Verification

ID verification is required in person at the surgery reception to ensure access is granted to patients/proxy users that have a legitimate reason to access a record. This will prevent access being granted to the wrong person and support the practice to adhere to stringent information security guidelines. Please provide 2 documents as **proof of identity** with the proxy access application, one of which must contain a photograph. Acceptable documents include passports, photo driving licences and bank statements. If none of the above are available, household bills may be accepted at the discretion of the Practice Management.

For practice use only

The patient's NHS number		The patient's practice computer ID number	
Identity verified by (initials)	Date	Method of verification	Vouching <input type="checkbox"/> Vouching with information in record <input type="checkbox"/> Photo ID and proof of residence <input type="checkbox"/>
Proxy access authorised by			Date
Date account created			
Date passphrase sent			
Level of record access enabled		Notes / comments on proxy access	

*If this email address is shared with others please consider whether you agree that it can be used to send you confidential information about your account, services used and health care.