



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.

PLEASE COMPLETE USING BLACK INK AND IN UPPER CASE

Section 1

I, _____ / _____ (name of patient and date of birth) give permission to my GP practice to give proxy access to online services to the following person(s):

| |
|--|
| |
| |

I indicate the proxy access permission I give below:

(Confirm which services your proxy can see)

| | | | | |
|-----------------------------------|-----|--------------------------|----|--------------------------|
| 1. Online appointments booking | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| 2. Online prescription management | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| 3. Accessing the medical record | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |

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.

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 2

I/we _____ (names of representatives) wish to have online access to the services ticked in the box above in Section 1 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 read and understood the information leaflet provided by the practice and agree that I will treat the patient information as confidential | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| 2. I/we will be responsible for the security of the information that I/we see or download | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| 3. 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 | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| 4. 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/we will treat any information which is not about the patient as being strictly confidential | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |

| | | | |
|-----------------------------------|--|------|--|
| Signature(s) of Representative(s) | | Date | |
| Signature(s) of Representative(s) | | Date | |

Please bring proof of ID (showing current address and date of birth) to register for Patient Access. We cannot register you without it. Family members have to use a unique email addresses for each person, even children.

Section 3

The patient

(This is the person whose records are being accessed)

| | | | |
|------------------|--|---------------|--|
| Last Name | | | |
| First Name | | | |
| Date of Birth | | | |
| Address | | | |
| 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.)

| | | | |
|-------------------------|-------|-------------------------|-------|
| Last Name | | Last Name | |
| First Name | | First Name | |
| Date of Birth | | Date of Birth | |
| Gender | M / F | Gender | M / F |
| Address | | Address | |
| Email | | Email | |
| Telephone Number | | Telephone Number | |
| Mobile Number | | Mobile Number | |
| Relationship to patient | | Relationship to patient | |

For practice use only

| | | | |
|----------------------------------|-------------------------------------|--------------------------|-----------------------------------|
| Patient's NHS number | | Patient's Practice ID | |
| 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 | Prospective | | |
| | Retrospective | | |
| Notes / comments on proxy access | | | |
| Did the patient come in? | Yes | <input type="checkbox"/> | No |
| | | | If NO, what was the reason given? |

PROXY CONSENT FOR PATIENT ACCESS (GP ONLINE SERVICES)

(to be handed out with proxy consent form)

Proxy access allows parents, family members, carers, care home staff, to have access to their patients'/dependants' online services accounts, in order to book appointments, request repeat medication and where applicable, view their medical record.

Anyone with capacity to do so may give informed consent to the practice to give proxy access to online services and the GP records. If the patient lacks capacity, proxy access may be given to a family member or carer either because they hold a Power of Attorney for health and welfare or because the GP judges it to be in the **patient's** best interests.

The proxy doesn't have to be a registered patient at the practice, BUT must be registered for online services on the GP system and always use their own login credentials. They should not have access to the **patient's** login credentials.

The practice can refuse or withdraw proxy access, if they judge that it is in the **patient's** best interests to do so.

The level of access is configured per patient for each proxy user, as they may care for more than one patient and need different levels of access.

Applying for Proxy Access

If you wish to apply for proxy access (essential for children under the age of 16 years) you must complete the Proxy Access form (available from reception). The form is split into the following Sections:

- 1 the 'patient' gives permission for the named 'representative' to have proxy access and the level of access being given. The patient must sign.
- 2 the 'representative' requests access to the 'patient's' online access and signs to understand their responsibility for safeguarding sensitive information. The 'representative' must sign.
- 3 this gives details (name, address, date of birth, contact details) for both the 'patient' and 'representative'.

The proxy user must bring proof of ID (showing current address and date of birth) to register for Patient Access. Registration cannot be made without it. Family members must have a unique email addresses for each person, even children.