**ASHFORD HEALTH CENTRE**

**Application form for proxy access to GP online services- For Children less than 12 years old and for requests for proxy access for adult patients**

**PLEASE NOTE IT MAY TAKE UP TO 4 WEEKS TO PROCESS APPLICATIONS**

**Section 1- PATIENT TO COMPLETE only where they can give consent for proxy access.**

If the patient does not have capacity to consent to grant proxy access (children < 12 years old and some adult patients) section 1 of this form to be omitted

I,………………………………………………….. (full 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.

|  |  |
| --- | --- |
| Signature of patient:  Date of Birth:  Address: | Date |

**Section 2- all applicants to complete**

The proxy is requesting access to:

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

**Section 3- PROXY TO COMPLETE- for parents/guardians of children < 12 years old and for adults who do not have capacity to consent (**The Lead GP or above must document in the clinical notes that the Patient’s capacity has been assessed with reference to this decision.)

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

for ……………………………………….……………………………………... (full name of child/ 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 | 🞏 |
| 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 | 🞏 |

|  |  |
| --- | --- |
| Signature of representative 1:  Full name: | Date |
| Signature of representative 2:  Full name: | Date |

**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:**  **Postcode:** | **Address : (tick if both same address 🞏)**  **Postcode:** |
| **Email:** | **Email:** |
| **Telephone:** | **Telephone:** |
| **Mobile:** | **Mobile:** |
| **Relationship to patient:** | **Relationship to patient:** |

**For practice use only**

|  |  |  |  |
| --- | --- | --- | --- |
| Patient NHS number: | | Practice computer ID number | |
| Identity of proxy and their legitimate reason for access verified by named administrator in face to face meetings  (initials): | Date | Method  Photo ID and proof of residence of proxy(2 pieces) 🞏  Proof of parental responsibility for children less than 12 years old 🞏  Proof of LPA or other suitable documentation for adults who lack capacity to consent 🞏 | |
| ID checks Authorised by named administrator : | | | Date: |
| Notes reviewed by named clinician: Dr | | | Date: |
| Access Approved / Not approved | | | Date: |
| Date account created | | | |
| Date passphrase sent | | | |