Consent to proxy access to GP online services

13–16 YEAR OLDS

Notes: 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.

If, as a parent, you are applying for access to your child's records, we will need you to confirm your parental rights. If your child is competent and able to understand the implications of your access, then we will need to get their consent between the ages of 13 to 16 years of age. Once the child reaches age 16 all proxy access will be stopped.

Please note that each application will be reviewed by the Patient's GP and we may contact you to arrange a meeting to discuss access.

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.

Signature of patient	Date

Section 2

1.	Online appointments booking	☐
2.	Online prescription management	☐
3.	Accessing the medical record for (name of patient)	☐

Section 3

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:

1.	I/we have read and understood the information leaflet provided by the practice	☐
2.	I/we will be responsible for the security of the information that I/we see or download	☐
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	☐
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	☐

Signature of representative	**Date**
Signature of representative	**Date**

If as a parent you are applying for access to your child's records, please confirm your parental responsibility. At least one of the following must apply and your parental rights must not have been removed by the courts. Please tick to indicate which apply

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- ☐ your name is on the birth certificate OR
- ☐ if you are the father, you were married to the mother at the time of birth OR
- ☐ you have been granted parental rights by the courts OR
- ☐ if you are the father, you have the agreement of the mother

- ☐ **my parental rights have not been removed by the courts**

Signature of parent……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

For practice use only

The patient's NHS number		
Identity verified by (initials)	Date	Method Vouching ☐ Vouching with information in record ☐ Photo ID and proof of residence (tick below) ☐ passport ☐ driving licence ☐ bank statement ☐ other (please record) ☐
Proxy access authorised by **PLEASE NOTE THIS MUST BE A GP PARTNER**		Date
Date account created		
Date passphrase sent/handed out		
Level of record access enabled Appointments ☐ Repeat Prescriptions ☐ Medication ☐ Allergies ☐ Other, please specify ☐		Notes / comments on proxy access