FORM 7

Consent to proxy access to GP online services for over 16 years (Adult)

The patient must sign this form in the presence of surgery staff.

Consent to proxy access to GP online services

Section 1

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 the Patient- please state	**Relationship to the Patient- please state**

Section 2 Patient to sign if they have capacity

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 sections 2 and 3 of this form may be omitted.

I,…….. (name of patient), give permission to the Elms Medical Practice to give the following people

…..……..……..

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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 3

To be completed by the patient – witnessed by a member of practice staff.

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

Section 4 Proxies to sign

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 and agree that I will treat the patient information as confidential	☐
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. I will treat any information which is not about the patient as being strictly confidential	☐

Signature/s of proposed representatives	Date

For practice use only STAFF MEMBER MUST SIGN

Verify patient's ID:

The patient's NHS number		EMIS number
Identity verified by (initials)	Date	Method of verification Vouching ☐ Vouching with information in record ☐ Photo ID and proof of residence ☐

Verify proxy 1's ID:

If more than one person wants access to the patient's record please obtain id from both parties. Confirm photographic ID has been checked: Passport ☐ Picture driving licence ☐	
Date	Verified by:

Verify proxy 2's ID:

If more than one person wants access to the patient's record please obtain id from both parties. Confirm photographic ID has been checked: Passport ☐ Picture driving licence ☐	
Date	Verified by:

Confirmation of Access:

Please put form in Liz's tray

Liz REFUSED: ask Emma to send a letter to patient.

Liz AGREED. Date access enabled on computer:

PLEASE SEND COMPLETED FORM TO SCANNING