**Consent To Proxy Access To GP Online Services**

**SECTION 1:- WHAT ONLINE ACCESS IS BEING REQUESTED?**

Please tick whichever box applies.

|  |  |
| --- | --- |
| 1. Booking appointments | 🞏 |
| 1. Requesting repeat prescriptions | 🞏 |
| 1. Accessing my medical record | 🞏 |

**SECTION 2:- WHO IS MAKING THE REQUEST?**

**If you are the patient and are making the request yourself for a representative to have online access to your medical record (we call this PROXY access), please complete Section 3 below and please note that you do not need to complete Section 4.**

**If you are making the request on behalf of the patient to have online access to their medical record (because the patient is not able to give consent) then please complete Section 4 below and please note that you do not need to complete Section 3.**

**SECTION 3:- REQUEST DIRECTLY FROM YOURSELF AS THE PATIENT**

I (please enter details below) give permission to my GP practice, Ellergreen Medical Centre, to give the following people ….………………………………………………………………..…………….. proxy access to the online services as indicated above in section 1.

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.

|  |  |
| --- | --- |
| Surname | First Name |
| Date of Birth | Email Address |
| Address & Postcode | |
| Telephone number | Mobile number |
| Signature of Patient | Date |

**SECTION 4:- REPRESENTATIVE OF THE PATIENT SEEKING PROXY ACCESS ON BEHALF OF THE PATIENT**

I/we (please enter details below) 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 | 🞏 |
| 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. I will treat any information which is not about the patient as being strictly confidential | 🞏 |

|  |  |
| --- | --- |
| **1st Representative** | **2nd Representative (if more than one)** |
| 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 |
| Signature | Signature |

**SECTION 5:- ELLERGREEN STAFF ONLY** *(please complete and sign)*

|  |  |
| --- | --- |
| **VERIFICATION**  Proof of photographic ID of proxy applicant seen  Name of staff member­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of staff member­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| **AUTHORISATION**  Proxy access authorised by (Name ­­­­­­­­­­­­­­­­­­­ ­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date ­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |