

Wellington Road Surgery
Child Aged 11-15 Consent to Proxy Access to GP Online Services

SECTION ONE – TO BE FILLED OUT BY PATIENT

(The person whose online records are to be accessed)

First Name:	Surname:
Date of Birth:	Email Address:
Full Address:	
Telephone number:	Mobile number:

I _____ (*name of patient*) give permission to Wellington Road Surgery to give the following person _____ proxy access to the online services indicated below:

Booking appointments	<input type="checkbox"/>
Requesting repeat prescription	<input type="checkbox"/>
Access to all / parts (delete as appropriate) of my medical record as currently available. Where permission is restricted to part of the records, please describe which areas are restricted: _____	<input type="checkbox"/>

Child Declaration - Please read before signing:

- *I give permission for the proxy named on page 2 to have access to my medical records and personal details held by the Practice via the Online Services – Patient Access.*
- *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 attached document for “Proxy Access for Children.”*
- *I am available to be contacted by the surgery at any point regarding my proxy.*
- *I understand that this consent will remain in force until I reach 16 years of age, when it will be automatically revoked. However, my doctor may, at my request, override this authority to allow access to my medical records via Patient Access/Online Services at any time.*

Signature of patient: _____ **Date:** _____

SECTION TWO – FOR PRACTICE USE ONLY

TO BE COMPLETED BY RECEPTION:		
Patients NHS Number:		
Identity of patient verified by (name of staff member)	Date	Method of verification Birth certificate / Passport <input type="checkbox"/> Vouching <input type="checkbox"/> Child present at request <input type="checkbox"/>

SECTION THREE - TO BE FILLED OUT BY REPRESENTATIVE OF PATIENT**(The person seeking proxy access to the patient's online services)**

First Name:	Surname:
Date of Birth:	Email Address:
Relationship to patient (circle option)	Carer/Child/Family member friend/mother/father
Full address:	
Telephone Number:	Mobile Number:

I _____ (*name of representative*) wish to have online access to the services ticked in the box overleaf for _____ (*name of the patient*)

- *I understand my responsibility for safeguarding sensitive medical information.*
- *I understand and agree with each of the following statements.*

Proxy Declaration – Please read before signing:

- *I have read and understood the information leaflet provided by the practice and agree that I will treat the patient information confidentially and won't disclose information to a 3rd party without agreement.*
- *I will be responsible for the security of the information that I see or download, and I will only use the information on the person that I have proxy access for in their best interest.*
- *I will contact the practice as soon as possible if I suspect that the account has been accessed by someone without the agreement of the patient.*
- *If I see information in the record that is not about the patient, or is inaccurate, I will contact the practice as soon as possible. I will treat any information which is not about the patient as being strictly confidential.*

Signature of representative: _____ **Date:** _____

The chosen person will have to show the surgery staff their photo ID and proof of address, for example a passport or photo driving licence and a letter from their bank or council tax statement.

You will be notified when access is granted via email or telephone. Please allow 14 days for processing

SECTION FOUR – FOR PRACTICE USE ONLY

TO BE COMPLETED BY RECEPTION:			
Identity of patients representative (proxy) verified by (name of staff member)	Date	Method of verification Photo ID and proof of residence (preferred) Vouching Vouching with information in record	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
TO BE COMPLETED BY ADMINISTRATOR:			
Proxy Access Authorised by:		Date:	
Date account created:		Account details provided:	
Notes/Comments			