Wellington Road Surgery

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	☐
Requesting repeat prescriptions	☐
Access to parts of my medical record as currently available	☐

Please read before signing:

- *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 TWO - *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.*

I have read and understood the information leaflet provided by the practice and agree that I will treat the patient information as confidential.	☐
I will be responsible for the security of the information that I see or download	☐
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

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SECTION THREE – FOR PRACTICE USE ONLY

TO BE COMPLETED BY RECEPTION:			
Patients NHS Number:			
Identity verified by (name of staff member)	Date	**Method of verification** Vouching ☐ Vouching with information in record ☐ Photo ID and proof of residence (preferred) ☐	
TO BE COMPLETED BY ADMINISTRATOR:			
Proxy Access Authorised by:		Date:	
Date account created:		Account details provided:	
Notes/Comments			