

**Consent to proxy access to GP online Services (patients 16+)**

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, section 1 of this form may be signed by the patients GP.

**Section 1: To be completed by the patient**

I,………………………………………………………………………………………(Name of patient) DOB:…………………................give permission to Cheadle Medical Practice to give the following people/person………………………………………………………………………………………………………………proxy access to the online services as indicted below.

|  |  |
| --- | --- |
| Booking appointments |  |
| Requesting repeat prescriptions |  |
| Access to my full medical record |  |

* 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 understood the leaflet provided by the practice.
* I confirm the personal information about myself and the proxy is correct

|  |  |
| --- | --- |
| Signature of patient/GP: | Date: |

**Section 2: To be completed by the Proxy/representative**

I………………………………………………………………….(Name of representative) wish to have online access to the services ticked in the box above

for……………………………………………………………….. (Name of patient) DOB:……………………………..

**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.  |  |
| I understand my responsibility for safeguarding medical information |  |

|  |  |
| --- | --- |
| Signature of Representative: | Date: |

**Section 3:**

**The patients details (details of the patients record to be accessed)**

|  |
| --- |
| Name: |
| Date of birth: |
| Address & postcode: |
| Email address: |
| Telephone Number: |
| Mobile Number: |

**The Representative (proxy user)**

|  |
| --- |
| Name: |
| Date of birth: |
| Address & postcode: |
| Email address: |
| Telephone Number: |
| Mobile Number: |
| Relationship to patient: |

**Section 4:**

**For Practice use**

|  |
| --- |
| **Patients NHS number:** |
| **Patients Emis ID:** |
| **Patients Identity verified by: Date:**Photo ID (please detail original ID provided)**1:** form of ID provided: 2: form of ID provided: |
| **Proxy access authorised by: Date:** |
| **Date account created:** |
| **Date PIN/passwords sent:** |
| **Level of access enabled:**Appointments, prescriptions & summaryFull record Access Notes:  |