**Proxy Access Request for Online Access, Information for Patients and Proxy applicants**

If you are requesting access to a dependent child under the age of 11, we will normally process your request straight away as long as you have 2 forms of ID and can verify your relationship to the child (for example, providing the child’s birth certificate).

If you are requesting proxy access for a child over the age of 11 or an adult, we will need to check your request with a Doctor. Please allow at least 1 working day for this.

The age of consent for a child accessing online services is 11 years of age. A child aged 11 and above, who the practice have assessed to have the required level of competency for decision making, can be granted access to their online records and can also grant consent for a parent/carer to have proxy access to their online services.

The individual requesting access must have 2 forms of ID. 1 current photo document (passport or driving license) and 1 proof of address (under 3 months old). If you are requesting access for a child over the age of 11 they will need to be present when handing the form in and provide their Identity documents as well.

The practice needs to review every request on a case-by-case basis and reach a decision on whether the chosen person can be granted access to the patient’s online services. There may be times when a GP could refuse the proxy applicant access (even if they hold a Health and Welfare Lasting Power of Attorney). The GP will always be acting in the patient’s best interest and must discuss the reason for refusal with the patient or in case of impaired capacity, the patient’s representative. Examples of reasons for refusal:

* The GP does not believe it is in the patient’s best interests for the chosen person to use their online services.
* Online services have been abused by either the patient or chosen person in the past.
* The GP is concerned that the chosen person will not keep the information safe.

As a practice we will remove access to patient’s online services for a number of reasons, including:

* When a child reaches the age of 11. They will need to either request access to their own online services or consent to a parent/carer having proxy access.
* We believe the patient is being forced to share their medical record.
* We believe the chosen person has misused the information.
* Death of the patient.

This list is not exhaustive.

The patient is responsible for informing the practice that they wish to withdraw their consent from the chosen person having access to their account. We will immediately remove this access when asked.

**Proxy Access Request Form – Online Access**

Please complete this in BLOCK capitals and bring to our Reception with the relevant Identity Verification Documentation.

|  |  |
| --- | --- |
| Your Full name |  |
| Your Date of Birth |  |
| Your Full address |  |
| Your home telephone  |  |
| Your mobile |  |
| Your email address |  |
| Your relationship to patient |  |

By signing you understand that you will be responsible for the security of the patient’s online services.

|  |  |
| --- | --- |
| **Signature of proxy** |  |

Office Use: Your ID

|  |  |  |
| --- | --- | --- |
| Authorised by: Signed  | Photo ID 🗆Proof of Residence 🗆  | **Date:** |

**Details of whose record you want to have proxy access to:**

|  |  |
| --- | --- |
| Patient’s full name |  |
| Patient’s Date of Birth |  |
| Patient’s contact telephone |  |

**If the patient is over the age of 11:** (If the patient is under 11 then you will only have access to booking appointments, ordering repeat medication and allergies and they do not need to sign.)

Please tick what access you would like to grant your chosen proxy user:

|  |  |  |  |
| --- | --- | --- | --- |
| Booking appointments |  | Immunisations |  |
| Ordering repeat medication |  | Test Results |  |
| Allergies |  | Problems |  |

By signing you are authorising the practice to give the person chosen on this form access to your online medical services. They will be able to act on your behalf in the areas ticked above. You can contact the practice at any time to restrict or remove their access and we will remove access if we suspect it is no longer in your best interest for the chosen person to act on your behalf.

|  |  |
| --- | --- |
| **Signature of patient** |  |

Office use: Patient’s ID

|  |  |  |
| --- | --- | --- |
| Authorised by: Signed  | Photo ID 🗆Proof of Residence 🗆  | **Date:** |