CEDAR BROOK PRACTICE

Consent for Proxy Patient Access

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, the first part of this form may be signed by the patient's named GP.

I……………………………………………(name of patient), give permission to Cedar Brook practice 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	

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

I…………………………………………………………(name of representative) wish to have online access

to the services ticked in the box above for ……………………………………………………….(name of 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 Patient (The person whose online records are to be accessed)

Surname	
First name	
Date of birth	
Address	
Email	
Telephone	
Mobile	

The Representative (the person seeking proxy access to the patient's online services)
The representative must produce their proof of photo ID and if registering on behalf of a child their child's birth certificate or passport.

Surname	
First name	
Relationship to patient	
Date of birth	
Address	
Email	
Telephone	
Mobile	