Weobley & Staunton on Wye Surgeries

**CONSENT TO PROXY ACCESS TO GP ONLINE SERVICES**

(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 omitted)

**Section 1**

I…………………………………………….. (name of patient), give permission to my GP practice to give the following people ………………………………………………… proxy access to the online services as indicated below in Section 2.

* 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 2**

|  |  |
| --- | --- |
| Online Appointments Booking | 🗆 |
| Online Prescription Management | 🗆 |
| Accessing the medical record for (insert name of patient) | 🗆 |

**Section 3**

I/We …………………………………………………………. (names of representatives) wish to have online access to the services ticked in the box above in Section 2 for

…………………………………………………………… (name of patient).

I/We understand my/our responsibility for safeguarding sensitive medical information and I/We understand and agree with each of the following statements:

|  |  |
| --- | --- |
| I/We have read and understood the information leaflet provided by the Practice and agree that I will treat the patient information as confidential | 🗆 |
| I/We will be responsible for the security of the information that I/ we see or download | 🗆 |
| I/We will contact the Practice as soon as possible if I/We suspect that the account has been accessed by someone without my/our agreement | 🗆 |
| If I/We see information in the record that is not about the patient or is inaccurate, I/We will contact the Practice as soon as possible. I will treat any information which is not about the patient as being strictly confidential. | 🗆 |

|  |  |  |  |
| --- | --- | --- | --- |
| Signature(s) of representative(s): |  | Date(s): |  |

**The Patient**

(This is the person whose records are being accessed)

|  |  |  |  |
| --- | --- | --- | --- |
| Surname |  | Date of Birth |  |
| First Name |  | | |
| Address |  | | |
|  |  | Postcode: |  |
| Email Address |  | | |
| Telephone Number |  | Mobile Number |  |

**The Representatives**

(These are the people seeking proxy access to the patient’s online records, appointments or repeat prescription)

|  |  |  |  |
| --- | --- | --- | --- |
| Surname |  | Surname |  |
| First Name |  | First Name |  |
| Date of Birth |  | Date of Birth |  |
| Address |  | Address |  |
| Postcode |  | Postcode |  |
| Email |  | Email |  |
| Telephone |  | Telephone |  |
| Mobile |  | Mobile |  |

**For practice use only**

|  |  |  |  |
| --- | --- | --- | --- |
| Patient NHS No: |  | EMIS No: |  |
| Identity verified by: |  | Date: |  |
| Method: | * Photo ID or Proof of Residence * Vouching * Vouching with Information in Record | | |
| Proxy Access Authorised by: |  | Coded in Notes:  (Code 9RN & 912P) |  |
| Date Account Created: |  | Date Password Sent: |  |
| Level of Record Access Enabled: | * All * Appointments * Prescriptions * Medical Record * Limited parts * Contractual Minimum | | |
| Coded in Notes: | * Provision of access to PFS (8OC) * Registration for PFS Discontinued (8CT9) * Access to PFS Declined (9lX) | | |
| Notes/Explanation on proxy access: |  | | |