

SOUTH HERMITAGE SURGERY

Consent to proxy access to GP online services for child under 11 years

Note: For a child under 11 years a parent can be granted proxy access if they have parental rights.

The practice therefore needs to have a clear evidence of a parent's legal right. All mothers have automatic Parental rights, unless these have been removed. Most fathers have legal rights if they were married at the time of the birth OR from May 2006 parents are unmarried, but the father is named on the birth certificate.

- ii. The patient (This is the person whose records are being accessed)
The representatives (These are the people seeking proxy access to the patient's online records)
- iii. ID Verification is required for **ALL** representatives

Section 1

I am the mother of the child for whom proxy access is requested

Name: _____

I am the father of the child for whom proxy access is requested and I can supply evidence of this legal right (birth certificate / marriage certificate)

Name: _____

Section 2

| | |
|---|--------------------------|
| 1. Online appointments booking | <input type="checkbox"/> |
| 2. Online prescription management | <input type="checkbox"/> |
| 3. Accessing the medical record for * (name of patient) | <input type="checkbox"/> |

*A GP needs to approve it is appropriate for access to be given to the patients' medical records

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:

| | |
|--|--------------------------|
| 1. I/we have read and understood the information leaflet provided by the practice and agree that I will treat the patient information as confidential | <input type="checkbox"/> |
| 2. I/we will be responsible for the security of the information that I/we see or download | <input type="checkbox"/> |
| 3. 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 | <input type="checkbox"/> |
| 4. 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 | <input type="checkbox"/> |

| | |
|---------------------------------|--------|
| Signature/s of representative/s | Date/s |
|---------------------------------|--------|

Section 4

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.) ** Identification verification is required to proceed eg driving licence / passport

| RELATIONSHIP TO CHILD: | RELATIONSHIP TO CHILD: |
|------------------------|--|
| Surname: | Surname: |
| First name: | First name: |
| Date of birth: | Date of birth: |
| Address: | Address: (tick if both same address <input type="checkbox"/>) |
| Postcode: | Postcode: |
| Email: | Email: |
| Telephone: | Telephone: |
| Mobile: | Mobile: |

Section 5:

Consent to proxy access to GP Online Services (if patient has capacity)

- I..... (name of patient), give permission to my GP practice to give the following person/people proxy access to the online services as indicated in Section 2 of this form.
- 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 organisation.

| | | | |
|--------------------------|--|-------------|--|
| Patient signature | | Date | |
|--------------------------|--|-------------|--|

For practice use only

| | | | |
|---|------|--|--|
| The patient's NHS number | | The patient's practice computer ID number | |
| Identity verified by (initials) | Date | Method of verification Vouching <input type="checkbox"/> Vouching with information in record <input type="checkbox"/> Photo ID and proof of residence <input type="checkbox"/> Birth Certificate of child <input type="checkbox"/> | |
| Proxy access authorised by | | Date | |
| Date account created | | | |
| Date account key sent | | | |
| Level of record access enabled. Prospective <input type="checkbox"/> Retrospective <input type="checkbox"/> All <input type="checkbox"/> Limited parts <input type="checkbox"/> Contractual minimum <input type="checkbox"/> | | Notes / comments on proxy access | |