


<p>The Alresford Surgery Station Road Alresford SO24 9JL</p>	
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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 person 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
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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"/>

Section 3

I..... (name of representative) wish to have online access to the services ticked in the box above in section 2

for (name of patient).

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

1. I 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 will be responsible for the security of the information that I see or download	<input type="checkbox"/>
3. I will contact the practice as soon as possible if I suspect that the account has been accessed by someone without my/our agreement	<input type="checkbox"/>
4. 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	<input type="checkbox"/>

Signature of representative	Date
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The patient

(This is the person whose records are being accessed)

Surname	Date of birth
First name	
Address	
Postcode	
Unique email address (Not to be shared by another user)	
Telephone number	Mobile number

The representative

(This is the person seeking proxy access to the patient's online records, appointments or repeat prescription.) **ALL SECTIONS MUST BE COMPLETED.**

Surname	Date of birth
Relationship to patient	
First name	
Address	
Postcode	
Unique email address (Not to be shared by another user)	
Telephone number	Mobile number

For practice use only

The patient's NHS number		The patient's practice computer ID number	
Patient Identity verified by	Date	Method of verification Photo ID and proof of residence <input type="checkbox"/>	
Proxy Identity verified by	Date	Method of verification Photo ID and proof of residence <input type="checkbox"/>	
Proxy access authorised by GP			Date
Date account created			
Proxy access countersigned by Caldicott Guardian			
Level of record access enabled		Notes / comments on proxy access	
Prospective <input type="checkbox"/>			
Retrospective <input type="checkbox"/>			
All <input type="checkbox"/>			
Limited parts <input type="checkbox"/>			
Contractual minimum <input type="checkbox"/>			