Aireborough Family Practice

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.
Our practice policy is not to grant proxy access for children aged 11yrs and over.

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.

Signature of patient	Date

Section 2

1. Online appointments booking	☐
2. Online prescription management	☐
3. Accessing the medical record for (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:

1. I/we agree that I/we will treat the patient information as confidential	☐
2. I/we will be responsible for the security of the information that I/we see or download	☐
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	☐
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	☐

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.)

Surname	Surname
First name	First name
Date of birth	Date of birth
Address Postcode	Address (tick if both same address ☐) Postcode
Email	Email
Telephone	Telephone
Mobile	Mobile

Acceptable Identity Evidence

Identity Proofing and Verification of an Individual, the options for presentation of documents are as follows:

Child if under 11years Birth certificate only

ADULT – Patient & Proxy Requester

- **Two pieces of evidence.**
- **one piece of evidence must include a photograph.**

PLEASE TICK DOCUMENTS YOU ARE SUBMITTING			
• Birth certificate	☐	• Passport	☐
• Adoption certificate	☐	• Utility Bill	☐
• Marriage certificate	☐	• Bank account	☐
•Power of Attorney for Health and Welfare	☐	• Full UK driving license	☐

For practice use only

<table>
<tr><td colspan="2">The patient’s NHS number</td><td colspan="2">The patient’s practice computer ID number</td></tr>
<tr><td>Identity verified by (initials)</td><td>Date</td><td colspan="2">Method of verification
Vouching ☐
Vouching with information in record ☐
Photo ID and proof of residence ☐</td></tr>
<tr><td colspan="3">Proxy access authorised by</td><td>Date</td></tr>
<tr><td colspan="4">Date account created</td></tr>
<tr><td colspan="4">Date passphrase sent</td></tr>
<tr><td colspan="2">Level of record access enabled

Prospective ☐
Retrospective ☐
All ☐
Limited parts ☐
Contractual minimum ☐</td><td colspan="2">Notes / comments on proxy access</td></tr>
</table>