Appendix 6 **Application for Access to Online Services (Proxy Under 11)**

**Consent to proxy access to GP online services (for parents, carers, etc.)**

**Appointments, Prescriptions and My Medical Record**

**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 – Patient (**This is the person whose records are being accessed)

|  |  |  |
| --- | --- | --- |
| Name | Date of Birth | Age |
| Address and Postcode  |
| Telephone number | Mobile number |

**Section 2 – Access Requested**

|  |  |
| --- | --- |
| 1. Online appointments booking | 🞏 |
| 2. Online prescription management | 🞏 |
| 3. Access to all of medical record (**coded entries**) | 🞏 |
| 4 Access to part of patients medical record please specify including dates  | 🞏 |

**Section 3 (representative/proxy to complete)**

(This is the people seeking proxy access to the patient’s online records, appointments or repeat prescription.)

I/we …………………………………………………………………………………………. (Name 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:

**Declaration**

|  |  |
| --- | --- |
| 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
 | 🞏 |
| 1. I/we agree to use the system in a responsible manner in accordance with all instructions given to me/us by the practice. If not access may be withdrawn
 | 🞏 |
| 1. If I/we see information which does not relate to the person I/we care for, I/we will immediately log out and report the matter to the practice as soon as possible
 | 🞏 |
| 1. I/we agree that it is my responsibility to keep the username and passwords secure. If I/we think these have been shared inappropriately I/we will rest them using the instructions supplied and inform the practice.
 | 🞏 |
| 1. If I/we choose to share the information contained within the record I/we do so at my/our own risk
 | 🞏 |
| 1. I/we am/are responsible for keeping safe any information I/we may print from the record
 | 🞏 |
| 1. I/we understand that online access is granted at the discretion of the practice, taking into account the best interests of the patient. I/we will be informed of any decision to withdraw the service. Please note, this does not affect the rights of Subject Access under the Data Protection Act
 | 🞏 |
| 1. If I/we notice any inaccuracies with the record, I/we will inform the practice manager as soon as possible of any errors or omissions
 | 🞏 |
| 1. I/we understand that I may see information on the record that I was unaware of/have forgotten about that could cause distress
 | 🞏 |
| 1. I/we agree to inform the practice immediately if I/we no longer have responsibility for the patients care
 | 🞏 |
| 1. I/we understand that the access to the record will be withdrawn on the patients 11th birthday
 |  |

**The Representative/Proxy** (this is the person seeking proxy access to the patient’s online records, appointments or repeat prescription)

|  |  |
| --- | --- |
| Surname | First name |
| Date of birth | Relationship to Patient |
| Address |
| Email | Telephone |
| Signature of representative | Date |

**The Representative/Proxy** (this is the person seeking proxy access to the patient’s online records, appointments or repeat prescription)

|  |  |
| --- | --- |
| Surname | First name |
| Date of birth | Relationship to Patient |
| Address |
| Email | Telephone |
| Signature of representative | Date |

**For practice use only (scan form to clinical record)**

|  |  |
| --- | --- |
| The patient’s NHS number | The patient’s practice computer ID number |
| Identity verified by(initials) | Date | **Method Patient**Under 11’s birth certificate required (Reception staff) 🞏  |
| Identity verified by(initials) | Date | **Method Proxy Requestor**Vouching (Reg’d GP/PM/Nurse/Secretary) 🞏Vouching with information in record (Reg’d GP/PM/Nurse/Secretary) 🞏2 ID Documents. One Photo ID (Reception staff) 🞏 |
| Date account created/Paperwork given |
| Date passphrase sent  |
| Level of record access enabled  Booking appointments 🞏 Repeat Medication 🞏  | Medical Record Prospective 🞏 All 🞏Limited Parts 🞏 Contractual Minimum 🞏 | Notes / comments on proxy access |
| Proxy access authorised by (Practice Manager or Registered GP only) | Date |

**Review is required for all requests for Medical Record Access; please ensure forms are passed to PM**