SKEGBY FAMILY MEDICAL CENTRE

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

1. Online appointments booking	☐
2. Online prescription management	☐
3. Limited access to parts of the medical record for (name of patient) **Please note: This aspect of the service is not available for patients under the age of 11**	☐
4. Access to detailed coded information **Please note: This aspect of the service is not available for patients under the age of 11**	☐

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	☐
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	☐
5. I/we understand some of the entries in my detailed coded record will be made by administrators and not clinical staff, but that the entries have been authorised by a clinician.	☐
6. I/we confirm that the information given on this slip is complete and correct to the best of my knowledge, and that should any of my contact details change I will notify the surgery as soon as this change takes place.	☐

Signature/s of representative/s	Relationship to Patient	Date/s

The patient (This is the person whose records are being accessed)

Surname	Date of birth
First name	
Address Postcode	
Email address **Please note: Your email address may be used to send confidential data e.g. results, it is not advisable for patients to have the same email address. Please be advised that the practice cannot be held responsible for information sent to a shared email address which has been supplied for more than one patient.**	
Telephone number	Mobile number Do you consent to contact via SMS text? ☐ Yes

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

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 – Please State
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
Contractual minimum √
Other……</td><td colspan="2">Notes / comments on proxy access</td></tr>
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