**PROXY ACCESS REGISTRATION FORM FOR ONLINE SERVICES**

**SECTION ONE: Patient Details (person whose record will be accessed)**

I give permission to my GP practice to allow the following people proxy access to the online services section of my medical record.

|  |  |  |  |
| --- | --- | --- | --- |
|  Patient Name: |  | Date of Birth |  |
| Address: |  Post Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Home Phone: |  | Mobile Phone |  |
| Email: |  | Today Date: |  |

Please tick below to confirm you have and understood the following:

|  |  |
| --- | --- |
|  | *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* |
|  | *If I choose to share my information with anyone else, this is at my own risk*  |
|  | *If I think that I may come under pressure to give access to someone else unwillingly I will inform the practice as soon as possible* |

**Signature (if 16 or over) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SECTION TWO: Proxy User Details (person who will be granted access to the above patient’s record)**

|  |  |
| --- | --- |
|  | I wish to have access to the online service section of the above patient’s medical records. |
|  | I understand my responsibility for safeguarding sensitive medical information and I understand and agree to the following statements  |
|  | I confirm I have parental responsibility (under11) /or consent above if 16 plus  |
| Patient Name: |  | Relationship to patient |  |
| Date of birth |  | Home Phone:Mobile Phone |  |
| Address: |  Post Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Email: |  | Today Date: |  |

Please tick below to confirm you have and understood the following:

|  |  |
| --- | --- |
|  | *I will treat patient information as fully confidential*  |
|  | *I will be responsibility for the security of this account, and the information that I see or download*  |
|  | *If I suspect that the account has been accessed by someone without the patient’s consent, I will inform the practice as soon as possible* |
|  | *If I choose to share this information with anyone else, this is at my own risk*  |
|  | *If see information in this record that is not about patient or in inaccurate, I will inform the practice as soon as possible* |
|  | *If I think that I may come under pressure to give access to someone else unwillingly I will inform the practice as soon as possible* |
|  | ***The practice reserves the right to terminate access at any point if it is thought that it is in the best interests of the patient or if the services are being misused*** |

|  |  |
| --- | --- |
| Signature: |  |

|  |
| --- |
|  **PRACTICE USE ONLY** |
|  | Identity Verified (under 11 years) |  | Parental responsibility verified (under 11 years) |  | Login details given to parent(under 11 years) |
|  | Identity verified(over 16 years)  |  | Consent received(over 16 years) |  | Login details given to \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Staff Initials \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_