**Shotfield Medical Practice**

[**www.shotfieldmedicalpractice.co.uk**](http://www.shotfieldmedicalpractice.co.uk/)

**Patient Online: Proxy Access to GP online service registration & consent form**

Please complete in full and write clearly and in block capitals

|  |  |
| --- | --- |
| Full Name (**Patient)** |  |
| Date of birth |  |
| Telephone number |  |

*I.…………………………………........................(Patient name), give permission to my GP practice to give …….………………………….……………..…. (Representative name) proxy access to the online services as indicated below (please tick all that apply. I reserve the right to reverse any decision I make in granting proxy access at any time. I do understand the risk of allowing someone else to have access to my health records. I have read and understand the information leaflet provided by practice.*

|  |  |
| --- | --- |
| 1. Booking and cancelling GP appointments
 | 🞏 |
| 1. Requesting repeat prescriptions
 | 🞏 |
| 1. The following data is available to view by default: allergies and adverse reactions, medications history.
 |  |
| Signature of patient: | Date: |

|  |  |
| --- | --- |
| Full Name  |  |
| Date of Birth |  |
| Address |  |
| Relationship to Patient |  |
| Email |  | Home/Mobile Tel Nos |  |

**Application for proxy online access**

*I …………………………………………………….…..(name of representative) wish to have proxy access to the services indicated above for ………..………………...…………(patient name). I do understand my responsibility for safeguarding sensitive medical information and I understand and agree with each of the following statements (please tick all items, sign and date or this application cannot be processed)*

|  |  |
| --- | --- |
| I have read and understood the information leaflet provided by the practice and agree that I will treat the patient information as confidential |  🞏 |
| I will be responsible for the security of the information that I/we see or download | 🞏 |
| I will contact the practice as soon as possible if I suspect that the account has been accessed by someone without my agreement |  🞏 |
| 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 |  🞏 |
| Signature of representative: | Date: |

**For practice use only**

|  |  |  |  |
| --- | --- | --- | --- |
| Identity verified through(tick all that apply) | Vouching 🞏 Vouching with information in record 🞏 Photo ID 🞏 Proof of residence 🞏 | Initials of verifier: | Date: |
| NHS number |  | Practice computer ID number |  |
| Date and name of person accepting account  |  |