# [cid:image001.png@01D3473D.79A8F750](http://www.snaithrawcliffemedicalgroup.com/Home)

# 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 signed by the patient’s named GP.

# Section 1

# I,………………………………………………………… (name of patient), give permission to The Snaith & Rawcliffe Medical Group to give the following people……………………………………………………………………………………

# Proxy access to online services as indicated below in section 2.

# Section 2

|  |  |
| --- | --- |
| Booking appointments: | Yes/No |
| Requesting repeat prescriptions: | Yes/No |
| Access to parts of my medical record as currently available: | Yes/No |

# 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 3

# I………………………………………………………….. (name of representative) wish to have online access to the services ticked in the box above in section 2

# For………………………………………………………. (name of patient).

# I understand my responsibility for safeguarding sensitive medical information

# I understand and agree with each of the following statements:-

# 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 see or download.

# I will contact the practice as soon as possible if I suspect that the account has been accessed by someone without the agreement of the patient.

# 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:

# The Patient (the person whose online records are to be accessed)

|  |  |
| --- | --- |
| Surname | Date of birth |
| First name | |
| Address  Postcode | |
| Email address | |
| Telephone number | Mobile number |

# 

**The Representative** (the person seeking proxy access to the patient’s online services)

|  |  |
| --- | --- |
| Surname | Date of birth |
| First name | |
| Address  Postcode | |
| Email address | |
| Telephone number | Mobile number |

# 

# *For Practice Use Only:*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Patient NHS number | | | Practice computer ID number | |
| Identity verified by (initials) | Date | | Method  Vouching   Vouching with information in record   Photo ID and proof of residence  | |
| Proxy Access Authorised by | | | | Date |
| Date account created | | | | |
| Date passphrase sent | | | | |
| Level of record access enabled  Detailed coded record   Limited parts  | | Notes / explanation | | |