De Montfort Surgery

Student Health Centre,
100 Mill Lane, Leicester, LE2 7HX
Tel: (0116) 222 7272 **Fax:** (0116) 295 4090
Email: demontfortsurgery@leics.nhs.uk
Website: www.demontfortsurgery.co.uk

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. Proxy access for a child will automatically be revoked when the child reaches the age of 12.

Section 1

I, …….. (Name of patient), gives 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

TIER 1

I, the patient wish to have access for myself to the following online services (tick all that apply):

1. Booking appointments	☐
2. Requesting repeat prescriptions	☐
3. Limited access to parts of my medical record (Summary Care Records)	☐

TIER 2

I, the patient wish to give the above named person access to the following online services (tick all that apply):

1. Booking appointments	☐
2. Requesting repeat prescriptions	☐
3. Detailed coded record access	☐

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	☐
1. I/we will be responsible for the security of the information that I/we see or download	☐
2. 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	☐
3. 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	☐

Signature/s of representative/s	Date/s

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The Patient

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

(This is the person whose records are being accessed)

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	Address (tick if both same address ☐)
Postcode	Postcode
Email	Email
Telephone	Telephone
Mobile	Mobile

PLEASE NOTE: THE PRACTICE WILL RESPOND TO THIS APPLICATION WITHIN 21 DAYS. PLEASE ENSURE YOUR CONTACT DETAILS AND EMAIL ADDRESS IS UP TO DATE, TO ALLOW A TIMELY RESPONSE

For practice use only

Patients NHS number		
Identity verified by staff member (initials)	Date	Method of verification 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 TIER 1 Y/N TIER 2 Y/N		Notes / comments on proxy access