HEATH LANE MEDICAL CENTRE  
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Please provide photo ID (passport or photocard driving license) **and** proof of address for all those **requesting** proxy access

The proof of address **must** be an original bank/ credit card statement, council tax letter, utility bill (not mobile phone), rental agreement, mortgage statement, pay slip, P45/ P60

The proof of address **must** be dated within the last **three months**

**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.

|  |  |
| --- | --- |
| Signature of patient | Date |

**Section 2**

|  |  |
| --- | --- |
| 1. Online prescription management | 🞏 |
| 1. Accessing the medical record for (name of patient) | 🞏 |

**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 agree that I/we 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 | 🞏 |
| 1. 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 | 🞏 |
| 1. 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 |

**Section 4**

**The patient**

(This is the person whose records are being accessed)

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

**The representatives**

(These are the people seeking proxy access to the patient’s online records.)

|  |  |
| --- | --- |
| 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 |
| Relationship to patient: | Relationship to patient: |