ONLINE PROXY ACCESS APPLICATION FORM

Children 0-10yrs ONLY

From the ages of 0 – 10 years a parent or guardian is allowed access to their childs medical records. This may include access to medications, appointments, immunisations ect. However, when your child turns 11 our clinical system will automatically remove your proxy access and your child will be required to complete their own application form if they wish for proxy access to continue.
If you have any questions, please speak to a member of our reception team.

PLEASE COMPLETE ALL PAGES IN BLOCK CAPITALS IN BLACK INK

SECTION 1: The Childs Personal Information

Please note: The child's birth certificate or red child health book must be provided as proof of ID

Surname:	First Names:
DOB: / /	NHS Number:
Gender: Male ☐ Female ☐ Prefer to self-describe as: _____	
Home Address: Post Code:	

SECTION 2: PROXY User Information (Adult acting on behalf of the child)

Please note: The PROXY User must provide proof of photographic ID

Title:	Surname:
First Names:	DOB: / /
Home Address: Post Code:	
Home Number:	Mobile Number:
Email Address:	

SECTION 2a: PROXY User Declaration

☐ I am the birth mother

☐ I am the birth father and married to the mother at the time of the child's birth or subsequently

☐ I am the birth father and ***not*** married to the mother, but my name is on the birth certificate

☐ I am an adoptive parent

☐ I am the child legal guardian

☐ I have court-appointed parental responsibility

☐ Other – Please Specify: _____

I wish to have access to the following online services for the named child
(Please tick all that apply)

Booking Appointments	☐
Requesting Repeat Prescriptions	☐
Updating contact details (demographics)	☐
Secure online access to the child's electronic GP record	☐

I understand my responsibility for safeguarding sensitive medical information.
I understand and agree with each of the following statements:

I will be responsible for the security of the information that I see or download	☐
If I choose to share information with anyone else, this is at my own risk	☐
I will contact the practice as soon as possible if I suspect that is account has been access 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 _____

Print Name (Block Capitals) _____

Date ____ /____ /_____

SECTION 3: OFFICE USE ONLY

Confirmation of CHILD'S ID (Which document was seen?)	Date of document:
Confirmation of PROXY USER photo ID (Which document was seen?)	Date of document:
Name of staff verifying full completion of form (In capitals)	Today's Date:

Proxy Access Authorised by:	Date Account Created:
Date Account Details Sent:	Level of access enabled:
REMINDER: Scan this form to the patient's records	

END OF FORM