ONLINE PROXY ACCESS APPLICATION FORM

For children aged 11-15yrs ONLY

Children aged 11 – 15yrs can:

1. Access their own GP services online
2. Allow a parent/carer/guardian access to some or all services (Proxy access)
3. Allow a combination of 1 & 2

Please note: The childs GP may need to discuss online access with him/her and/or any proxy users applying for access on the child behalf

SECTION 1: Patient/Child Details

Please note: The patient must provide ID such as birth certificate, passport or provisional driving licence

Surname:	Address:
Forename:	Postcode:
DOB: / / Age:	Contact Number:
Email Address:	

SECTION 2: Accessing YOUR OWN Online Services

I would like access to the following services

Note: Leave all unticked, and do not sign if you DO NOT want your own access but would like to allow proxy access (point 2 above)

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

PATIENT DECLARATION

- 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 this account has been accessed by someone without my agreement
- If I see information in the record that is not about me or is inaccurate, I will contact the practice as soon as possible. I will treat any information which is not about me as being strictly confidential

Signature of Child:	Date:

SECTION 3: Proxy Access - Patient Consent

IMPORTANT: You can choose which services to allow your parent/guardian/carer to be able to access online

I give permission to my GP practice to give the person listed below proxy access to the following services on my behalf (Please tick all that apply)

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

PATIENT DECLARATION

- 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 proxy access to my health records, should I have allowed this

Signature of Child:	Date:

SECTION 3a: Proxy Access - Proxy Access User Agreement

Proxy User Details

Surname:	Address:
Forename:	
DOB: / / Age:	Postcode:
Home Number:	Mobile Number:
Email Address:	

PROXY USER DECLARATION

- 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 this account has been accessed by someone without my agreement
- If I see information in the record that is not about the child or is inaccurate, I will contact the practice as soon as possible. I will treat any information which is not about the child as being strictly confidential

Signature:	Date:

SECTION 4: OFFICE USE ONLY

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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:

Online Access Authorised by:	Date Account Created:
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