ONLINE PROXY ACCESS APPLICATION FORM

Adults aged 16yrs and over ONLY

Patients over the age of 16 years are still able to appoint someone to support their care through online proxy access if they wish. This could include a family member, a friend, carer, or care home staff. The patient must have a clear understanding of the level of access being given and provide explicit consent. They must also trust that the person they are giving access to will not use their information inappropriately.

PLEASE COMPLETE ALL PAGES IN BLOCK CAPITALS IN BLACK INK

Section 1: Patient Details

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

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

I give permission to The Swan Medical Group to give the following person (Proxy User Name) _____ proxy access to the online services indicated below.

Booking Appointments	☐
Requesting Repeat Prescriptions	☐
Updating my contact details (demographics)	☐
Secure online access to my full electronic GP record	☐

Section 2: Patient Declaration

DECLARATION

If the patient is unable to provide informed consent to allow proxy access (e.g. has severe dementia, learning difficulties etc.) please proceed to section 2a

- I give permission to my GP practice to give the person listed below proxy access to the above-indicated online services on my behalf
- 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 authorised this

Signature _____

Print Name (Block Capitals) _____

Date ____ /____ /_____

Section 2a: If the patient is unable to give consent

Please provide details as to why the patient is unable to give consent, whether LAP is on force etc:

Section 3: Proxy User Details

Please note: The proxy user must provide proof of photographic ID

Surname:

Forename:

DOB: / /

Email Address:

Home Number:

Address:

Postcode:

Mobile Number:

Section 4: Proxy User Declaration

DECLARATION

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 eith 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 patient or is inaccurate, I will contact the practice as soon as possible

Signature _____

Print Name (Block Capitals) _____

Relationship to the patient_____

Date ____ /____ /_____

Section 5: OFFICE USE ONLY

Confirmation of PATIENT's photo ID (Which document was seen?)	Date of document:
Confirmation of PROXY USER's 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 consent form to the patient's records	

END OF FORM