APPENDIX 2 – PROXY APPLICATION FORM

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 detailed on this form. (Specified by marking X in relevant boxes on this form.)

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

1. Booking appointments	☐
2. Requesting repeat prescriptions	☐
3. GP test results (e.g. blood tests, urine tests)	☐
4. Immunisation records (including COVID)	☐

Section 2

I/we… .....(Names of representatives) wish to have online access to the services for…… (Name of patient).

Our relationship to…… (Name of patient) is……
……..

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 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

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, appointments or repeat prescription.)*

Surname	Surname
First name	First name
Date of birth	Date of birth
Address Postcode	Address (tick if both same address ☐) Postcode
Email	Email
Mobile	Mobile

If access to the full medical record is required please indicate the reason for this below and tick here ☐

.....

.....

Proxy access requests to records are reviewed by a GP and can take up to 6-8 weeks to process. Thank you for your patience.

For Practice use only

Patient Verification

The Patient's NHS Number:	
The Patient's Practice Computer ID Number:	
Method of Patients Verification: (please select all appropriate)	
Photo ID	
Birth or Adoption Certificate	
Proof of Address	
Verified By: (Middlewood Staff Member)	
Sign:	
Print:	
Date:	

Proxy Verification

Proxy's NHS Number If Applicable:	
Proxy's Computer ID Number if applicable:	
Method of Proxy Verification: (please select all appropriate)	
Photo ID	
Birth or Adoption Certificate	
Proof of Address	
Verified By: (Middlewood Staff Member)	
Sign:	
Print:	
Date:	

Parental Responsibility Verification

This needs to be completed when a Parent has a different surname to the Child

The Patient's NHS Number:	
The Patient's Practice Computer ID Number:	
Method of Proxy Verification: (please select all appropriate)	
Full Birth or Adoption Certificate	
Parental Responsibility Agreement	
Verified By: (Middlewood Staff Member)	
Sign:	
Print:	
Date:	

For Practice use only

To be completed by Proxy access Team:

Proxy access authorisation:	
GP Signature:	
Print:	
Date:	
Date Account Created:	
Account Created by:	
Confirmation Sent by:	