**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.

Proxy access application will not be accepted from any third party commercial company i.e. insurance companies for solicitors.

**Proxy Access:** Parents may request a proxy access to their children’s records; this will cease automatically when the child reaches the age of **11**. Any subsequent access will need to be authorised by the patient subject to a Gillick competency test being completed.

***Under the new GDPR the age a patient is deemed Gillick Competent has been reduced from 16 to 13 years old. A Gillick competency test may be necessary after the age of 13 in certain situations but this will be a clinical decision.***

**Section 1**

I, …………………………………………………………………….. (Name of patient), give consent to the disclosure of my private medical information to:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I consent to the above having Proxy access to the online services as indicated below in **Section 2.** I am aware that this consent may be revoked by me at any time by writing to the practice. I understand the risks of allowing someone else to have access to my health records.

|  |  |  |  |
| --- | --- | --- | --- |
| **Signature** |  | **Date** |  |

**Section 2**

Please tick all that apply:

Full and open ended disclosure of any matter related to my medical record

Full disclosure of any matter related to my medical record for the period

(from) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (to) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Limited disclosure of the following aspects of my medical record:

Test Results Appointment Queries

Prescription Queries Referral Queries

Any Other matter related to my medical record, please state:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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 1/we understand and agree with each of the following statements:

Tick to agree that you will comply

|  |  |
| --- | --- |
| 1. I/we agree to 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 my record that is not about the patient, or 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 of representative/s** |  | **Date** |  |

**The Patient**

(This is the person giving proxy access to their on-line record to a representative).

|  |  |
| --- | --- |
| **Surname** | **Date of Birth** |
| **First Name** | |
| **Address** | |
| **Email Address** |  |
| **Telephone No:** | **Mobile No:** |

**The Representatives**

(These are the people seeking proxy access to the patient’s online records, appointments or repeat prescriptions).

|  |  |
| --- | --- |
| **Surname** | **Surname** |
| **First Name** | **First Name** |
| **Date of Birth** | **Date of Birth** |
| **Address** | **Address (tick if both same address**  [Type a quote from the document or the summary of an interesting point. You can position the text box anywhere in the document. Use the Drawing Tools tab to change the formatting of the pull quote text box.] |
| **Email** | **Email** |
| **Telephone No** | **Telephone No** |
| **Mobile No** | **Mobile No** |

**Proxy Access:** Parents may request proxy access to their children’s records; this will cease automatically when the child reaches the age of 11. Any subsequent proxy access will need to be authorised by the patient subject to a competency test being completed.

**For practice use only**

|  |  |  |  |
| --- | --- | --- | --- |
| The patient’s NHS Number | | The patient’s practice computer ID number | |
| Identity verified by (initials) | Date | Method of verification   * Vouching * Vouching with information in record * Photo ID & Proof of residence | |
| Proxy access authorised by | | | Date |
| Date account created | | |  |
| Date passphrase sent | | |  |
| Level of record access enabled   * Contractual Mininum * Other (please specify) …………………………………… | | | Notes/comments on proxy access |