**New Mill Street Surgery**

**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 as indicated below in section 2.

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 |

**Section 2 (Services)**

|  |  |  |
| --- | --- | --- |
| 1. Appointments (Allows user to view and manage appointments online) |  |  |
| 1. Prescription management (Allows user to view and request repeat medications online) |  |  |
| 1. Accessing the full medical record   If no restrictions specified the user will be given access to everything.  You can specify detailed services and period of time below: |  |  |
|  |  | Date From/To |
| 1. Demographics (Allows user to request an address change/update contact details online) |  |  |
| 1. Messaging (Allows user to receive and send secure non–urgent messages with the practice) |  |  |
| 1. Test Results (Allows user to view lab reports once seen and filed by the GP) |  |  |
| 1. Documents (Allows user to view letters and reports) |  |  |
| 1. Immunisations (Allows user to view vaccination and immunisation history) |  |  |
| 1. Problems (Allows user to see medical conditions) |  |  |
| 1. Consultations (Allows user to see the patient records written by the GP) |  |  |
| 1. Share Record (Enables user to share all or certain areas of their medical record for 24 hours using Patient Access) |  |  |

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

|  |  |
| --- | --- |
| 1. I/we have read and understood the information leaflet provided by the practice and agree that I will 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 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 |

**Section 4**

**The patient**

(This is the person whose records are being accessed)

|  |  |
| --- | --- |
| First name | Date of birth |
| Surname | |
| Gender | |
| 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.)

|  |  |
| --- | --- |
| Relationship to the patient (Carer/Child/Family Member/Friend/Mother/Father) | Relationship to the patient (Carer/Child/Family Member/Friend/Mother/Father) |
| Title | Title |
| First name | First name |
| Surname | Surname |
| Date of birth | Date of birth |
| Gender | Gender |
| Address  Postcode | Address (tick if both same address )  Postcode |
| Email | Email |
| Home Telephone | Home Telephone |
| Work Telephone | Work Telephone |
| Mobile | Mobile |
| Preferred communication method | Preferred communication method |
| Consent to receive SMS notifications Yes/ No | Consent to receive SMS notifications Yes/ No |
| Consent to receive email notifications Yes/ No | Consent to receive email notifications Yes/ No |

**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 and proof of residence  | |
| Proxy access authorised by | | | Date |
| Date account created | | | |
| Date passphrase sent | | | |
| Level of record access enabled    Prospective   Retrospective   All   Limited parts   Contractual minimum  | | Notes/ comments on proxy access | |
| Legal Basis Types   * Parental Responsibility (Under 16) * Patient not competent (Under 16) * Explicit Consent * Patient lacks capacity (Over 16)   **Note** In these circumstances, 4 methods or recording the legal basis are:   * *Lasting power of Attorney for health and welfare* * *Court Appointed deputy* * *Best Interests* * Clinician | | Legal Basis: (Allow Access/Reject/Decide Later)  Type: | |