PATFORD
House Partnership

Consent to Proxy Access to GP Online Services for a Specified Third Party

One form should be completed for every representative for whom Proxy access is being requested.

If the patient does not have capacity to consent to grant Proxy access and Proxy access is considered by the patient's GP to be in the patient's best interest, Section 1 of this form may be omitted and their GP may grant Proxy access on their behalf.

Patient Details:

Surname:	**Date of Birth:**	**Age:**
First name (s):		
Address:		
e-mail address:		
Telephone number:	**Mobile number:**	

Section 1: Permission

I ……. (name of patient) give permission for my GP Practice to give the following person

……
Proxy access to the Online Services identified in Section 3 below.

- 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 understood the Access to Online Services information leaflet provided by the Practice.

Signature of patient	Date
Witness (please ask another adult, other than your representative) to witness your consent	
Signature of Witness	Date
NAME AND ADDRESS OF WITNESS - PRINT	

Section 2: Complete if Patient is Unable to Grant Proxy Access

Signature of GP if it is deemed that the patient does not have capacity to grant proxy access:

Signature of GP	Date
GP NAME - PRINT	

Section 3: Services to be Accessed

1. Online appointments booking	☐
2. Online prescription management	☐
3. Detailed coded record (optional)	☐

Section 4: Representative's Details

Surname:	**Date of Birth:** **Age:**
First name (s):	
Address:	
e-mail address:	
Telephone number:	**Mobile number:**
Their relationship to you:	☐ Wife / Husband / Civil Partner (delete) ☐ Son / Daughter ☐ Other (please specify relationship): ……..

I ……. (name of representative) wish to have online access to the services ticked in Section 3 above for

……..…….

I understand my responsibility for safeguarding sensitive medical information and understand and agree with each of the following statements:

1. I have read and understood the information leaflet provided by the Practice and agree that I will treat the patient's information as confidential	☐
2. I will be responsible for the security o the information that I see or download	☐
3. 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. I will treat any information that is not about the patient as being strictly confidential.	☐

Signature of representative:	Date: