**Malmesbury Medical Partnership**

**Consent to PROXY access to GP online services**

**The patient** (This is the person whose records are being accessed)

|  |  |
| --- | --- |
| Surname: | First Name: |
| Date of birth: | |
| Address:  Postcode: | |
| Email address: | |
| Mobile number: | |

**The representative** (This is the person seeking proxy access to the patient’s online records, appointments or repeat prescription.)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Surname: | | | First Name: | | |
| Date of birth: | | | | | |
| Address:  Postcode: | | | | | |
| Email address |  | | | | |
| Mobile Number |  | | | | |
| Preferred method of contact | | Email | | SMS Text | Printout |

**Note**: If the patient does not have **capacity to consent** to grant proxy access and proxy access is considered by the practice GP to be in the **patient’s best interest** section 1 of this form may be omitted.

**Section 1:** I give permission to my GP practice to give the above, named 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’ have read and understand the information leaflet provided by the practice.

|  |  |
| --- | --- |
| Signature of Patient: | Date: |

**Section 2**

I wish to have access to the following online services (please tick all that apply)

|  |  |
| --- | --- |
| 1. Booking appointments | 🞏 |
| 1. Requesting repeat prescriptions | 🞏 |
| 1. Limited access to parts of the medical record | 🞏 |

**Section 3** (to be completed by Proxy representatives)

I the above named representative wish to have online access to the services ticked in the box above in section 2 for the above named patient.

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

|  |  |
| --- | --- |
| * I have read and understood the information leaflet provided by the practice and agree that I will treat the patient information as confidential |  |
| * I will be responsible for the security of the information that I/we see or download |  |
| * If I 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 of representative: | Date: |

**For practice use only**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Patient identity verified by staff member: | | | Date: | |
| Verification method | Vouched for 🞏 | Photo ID 🞏 | | |
| Proxy access authorised by : | | | | Date: |
| Record access enabled for contractual minimum 🞏 Refused 🞏 | | | | |
| Explanation: | | | | |