**Fern House Surgery**

**Application for Proxy access to GP online services**

Please complete this form if you are registered patient between the ages of 13-16 at our practice and would like to give proxy access for parent/carer/guardian to access your medical records. If you do not have capacity to complete this form, please contact your GP practice to discuss this further with your representative.

**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.

Signature of patient Date

**Section 2**

1. Online Appointments Booking [ ]

2. Online Prescription Management [ ]

3. Full Medical Records [ ]

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 [ ]

2. I/we will be responsible for the security of the information that I/we see or download [ ]

3. 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 [ ]

4. 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 [ ]

Signature of representative Date

**The Patient**

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

**Surname Date of Birth**

**First Name**

**Address Postcode**

**Email Address Telephone Number/s**

**The representatives**

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

**Surname Date of Birth**

**First Name**

**Address Postcode**

**Email Address Telephone Number/s**

**For practice use only**

***ID verification***

I confirm that I have seen evidence of an original photographic identification that matches the name, date of birth, and appearance of the nominated individual.

Receptionist name

Date

Signature

***GP agreement***

I authorize the above named person to have online access to the electronic medical records help by the practice for the above named patient. The patient does/does not have capacity to consent (please select as appropriate)

GP name

Date

Signature