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Five Oaks Family Practice

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**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 practise, to be in the patients’ best interest, section one 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.

|  |  |
| --- | --- |
| Surname | Date of birth |
| First name |
| Address  Postcode  |
| Home telephone numberMobile numberEmail address: |

I reserve the right to reverse any decision I make in granting proxy access to the online services 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.

Date

Signature of patient

**Section 2**

**PROXY USER**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Adult acting on behalf of the adult/child**I wish to access to the following below services on behalf of the above-named patient **I have responsibility.**Please tick one of the below:* I am the birth mother
* I am the birth father and married to the mother at the time of child’s birth or subsequently
* I am the birth father and *not* married to the mother, but the child
	+ was born after 01/12/2003 *and*
	+ my name is on the birth certificate
* I am an adoptive parent
* I am the child’s legal guardian
* I have court-appointed parental responsibility
* Other – please specify:

**I wish to have access to the following online services for the above patient(please tick all that apply):**

|  |  |
| --- | --- |
| Booking appointments | **🞏** |
| Requesting repeat prescriptions | **🞏** |
| Updating contact details (demographics) | **🞏** |
| Secure online access to the electronic GP record  | **🞏** |

* I will be responsible for the security of the information that I see or download
* If I choose to share information with anyone else, this is at my own risk
* I will contact the practice as soon as possible if I suspect that this account has been accessed by someone without my agreement
* If I see information in the record that is inaccurate, I will contact the practice as soon as possible
 |

**Section 3**

I/we…………………………………………………………………………………………..

(names of representatives) wish to have online access to the services ticked 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 I have read and understood the information leaflet provided by the practise and agree that I will treat the patient information as confidential  |  |
| 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. I will treat any information which is not about the patient as being strictly confidential  |  |

**The Representatives**

|  |  |
| --- | --- |
| Surname | Surname |
| First Name | First Name |
| Date of Birth | Date of Birth |
| Address | Address |
| Email | Email |
| Telephone | Telephone |
| Mobile | Mobile |

Signature/s of representative/s

Date

***For Practice use only: ID FOR BOTH PARTIES REQUIRED***

|  |  |  |
| --- | --- | --- |
| **Patient NHS number** | **EMIS ID number** | **GP** |
| **Identity verified by****(FULL NAME):****Sign:** **Date:** | **Patient ID: Tick all that apply:** **Personal vouching 🞏** **Vouching with information in record 🞏Birth Certificate or Red Book 🞏** |
| **PROXY ID: Tick all that apply:** **Personal vouching 🞏** **Vouching with information in record 🞏Birth Certificate 🞏****Passport or Photo Driving Licence 🞏** **Proof of residence 🞏** |
| **Advise proxy that the practice will contact to collect registration details if proxy is not already registered for online accessOtherwise, proxy will be automatically activated once GP has approved application** |

 **PLEASE RETURN FORM TO**

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