

Online services application form Children 13 years or younger

- Parents may request proxy access to their children's records; this will cease automatically when the child reaches the **age of 14**. Any subsequent proxy access will need to be authorised by the parent subject to Gp approval.

Before you proceed, please be aware that this form will not be processed unless you give us proof of identification for BOTH parties

The child- This is the person whose records are being accessed

| | |
|----------------|----------------|
| Name of child: | Date of Birth: |
| Address: | |

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

| | |
|---|--------------------------|
| 1. Booking appointments | <input type="checkbox"/> |
| 2. Requesting repeat prescriptions | <input type="checkbox"/> |
| 3. Limited access to parts of my detailed medical record e.g., test results, immunisations, problems and allergies. | <input type="checkbox"/> |

The representatives – these are the people seeking proxy access to the patient's online records.

| | |
|---|----------------|
| Full name: | Date of Birth: |
| Address: | |
| Post code: | |
| Relationship to patient: | |
| Email address: (I want to receive my registration details by email) | |
| Contact number: (I would like to be contacted when my registration details are ready to collect). | |

I understand my responsibility for safeguarding sensitive medical information and
I 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 information as confidential. | <input checked="" type="checkbox"/> |
| 2. I/ we will be responsible for the security of the information that I/we see or download. | <input checked="" type="checkbox"/> |
| 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. | <input checked="" type="checkbox"/> |
| 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/ we will treat any information which is not about the patient as being strictly confidential. | <input checked="" type="checkbox"/> |

Signature of patient: (Parent/guardian) _____ Date: _____

****Application may take up to 3 weeks to be processed****

