Online access application form – OTHER

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

- Proxy access application will not be accepted from any third party commercial company i.e. insurance company or solicitors.

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

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Section 1

Date: ________________

Details of the person's medical records that will be accessed

Full name:	Date of Birth:
Address:	

I wish to give access to following online services:

1. Booking appointments	❑
2. Requesting repeat prescriptions	❑
3. Limited access to parts of my detailed medical record e.g. test results, immunisations, problems and allergies.	❑

By signing your signature below, you agree to the following statements;

I am the person in section 1 and give permission to the Gp practice to give PROXY access to online services to the person named 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.
I have read and understand the information leaflet provided by the practice.

Signature of patient in section 1: ______________________________

Section 2

The representative – the person who will have access

Full name:	Date of Birth:
Address:	
Relationship to patient:	
Email: (I would like you to email me the registration details when they are ready)	
Contact number: (I would like you to contact me when the registration details are ready to collect)	

1. I have read and understood the information leaflet provided by the practice and agree that I will treat the information as confidential.	☑
2. I will be responsible for the security of the information that I/we see or download.	☑
3. I 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 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.	☑

By signing your signature below you agree with the following statements;

I am the person in section 2 and I will safeguard the information of the person in section 1 that I have been trusted with.
I understand my/our responsibility for safeguarding sensitive medical information and
I understand and agree with each of the following statements:

Signature of person named in section 2: ______________________________________

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