



PATIENT ONLINE PROXY ACCESS FOR A CHILD

Patient Details (This is the person whose records are being accessed)

Surname		Address
First name		
Date of birth		
Email address		
Mobile No.		

Details of the person making the request for proxy access on behalf of a patient e.g. parent/guardian/carer

Surname		Address
First name		
Date of birth		
Email address		
Mobile No.		

Relationship to the Patient

- At the age of 11 online proxy access will automatically be disabled. A letter will be sent at this time.
- Between the age of 11 - 16 online proxy access can continue with the young person's consent. This completed application form and proof of ID will need to be provided.
- Age 16+ online proxy access will be disabled automatically again as the young person is assumed to have the capacity to register for their own Patient Online account. A letter will be sent at this time.

Section 1

If the patient does not have capacity to consent to proxy access, or is under the age of 11, and proxy access is considered by the practice to be in the patient's best interest Section 1 may be omitted.

I, _____ (name of child) give permission to my GP practice to give the following people proxy access to the online services as indicated below in section 2.

Signature of patient	Date:
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Section 2

1. Online Appointment Booking	<input type="checkbox"/>
2. Online Prescriptions	<input type="checkbox"/>



Honor Oak Group Practice, 20 Turnham Rd, London SE4 2LA

3. Accessing Medical Records	<input type="checkbox"/>
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Section 3

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 understand and agree that I/we will treat all 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 my account has been accessed by someone without my/our agreement	?
4. If I/we see information in my record that it not about me, or is inaccurate I will log out immediately and contact the practice as soon as possible	?

Signature/s of representative/s
Date

Section 4

Please either email this completed form to lewccg.g85089-general@nhs.net or bring it into the surgery along with 2 forms of ID: one with a photo and one with your address (usually a utility bill, bank statement within the last 3 months).

For practice use only

The patient's NHS number	The patient's practice computer ID number	
Identity verified by receptionist (initials)	Date	Method of verification: Vouching <input type="checkbox"/> Birth certificate and proof of address <input type="checkbox"/> Vouching with information in record <input type="checkbox"/> Photo ID and proof of residence <input type="checkbox"/>
Date account created by admin:		
Date PIN sent by admin:		Email <input type="checkbox"/> Letter <input type="checkbox"/>
Level of record access enabled Prospective (from the date GP has approved the access) <input type="checkbox"/> Retrospective (01.04.2017) <input type="checkbox"/> All <input type="checkbox"/> Limited parts (specify) <input type="checkbox"/> Detail coded <input type="checkbox"/>	Notes / comments on proxy access	Authorised by GP Name: Date: Signature: