

RYE MEDICAL CENTRE
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 practice to be in the patient's best interest section 1 of this form may be omitted.

Section 1

I,..... (name of patient), give permission to my GP practice to give the following person 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.
- I have read and understand the information leaflet provided by the practice

Signature of patient (over age 11yrs):	Date
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Section 2

1 Online appointments booking	<input type="checkbox"/>
2 Online prescription management	<input type="checkbox"/>
3 Limited access to parts of the medical record for of patient) (Medication, Allergies, vaccinations)	<input type="checkbox"/>

Section 3

I..... (name of representative) wish to have online access to the services ticked in the box above in section 2

for (name of patient)

I understand my responsibility for safeguarding sensitive medical information and I understand and agree with each of the following statements:

1 I have read and understood the information leaflet provided by the practice and agree that I will treat the patient information as confidential	<input type="checkbox"/>
4 I will be responsible for the security of the information that I see or download	<input type="checkbox"/>
5 I understand we may read some information that could be unexpected or upsetting	<input type="checkbox"/>
6 I will contact the practice as soon as possible if I suspect that the account has been accessed by someone without my agreement	<input type="checkbox"/>
7 If I see information in the record that is not about the patient, or is inaccurate, I will contact the practice as soon as possible. I will treat any information which is not about the patient as being strictly confidential	<input type="checkbox"/>

Signature/s of representative/s	Date/s
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The patient

(This is the person whose records are being accessed)

Surname		Date of birth	
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First name			
Address			
Postcode			
Telephone number		Mobile number	

The representative

(The person seeking proxy access to the patient's online records, appointments or repeat prescription.)

Surname			
First name			
Date of birth			
Address			
Postcode			
Email			
Telephone			
Mobile			
Relationship to the patient			
Legal basis reason for proxy access	Parental responsibility	<input type="checkbox"/>	
	Power of Attorney	<input type="checkbox"/>	
	Guardian/Carer	<input type="checkbox"/>	

