Stratton Medical Centre
Consent to proxy access to GP online services (Under 11)

Note: A person with **documented** parental responsibility will have full proxy access to their child's online services, including the medical record. This access will be automatically restricted on the child's 11th birthday.

Section 1.

I …… *(name of patient),* give permission to my GP practice

to give the following ……

proxy access.

Signature of parent/guardian	Date

Section 2.

1. Online appointments booking	☐
2. Online prescription management	☐
3. Accessing the medical record for *(name of patient)*	
3.1 Access to records from / /	☐
3.2 Access to full medical records	☐

Reason records access required.

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 have read and understood the information leaflet provided by the practice 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	☐

Signature/s of representative/s	Date/s

Section 4

The patient

(This is the person whose records are being accessed)

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

The representatives

(These are the people seeking proxy access to the patient's online records, appointments or repeat prescription.)

Surname	Surname
First name	First name
Date of birth	Date of birth
Address Postcode	Address (tick if both same address ☐) Postcode
Email	Email
Telephone	Telephone
Mobile	Mobile

For practice use only

The patient's NHS number		
Identity verified by (initials)	Date	**Method of verification** **Parental Responsibility verified ☐** **Photo ID and proof of residence from the parent/guardian ☐**
Proxy access authorised by **(Admin Team)**		Date
Date account created		
Date passphrase sent		

Level of record access approved		Notes / comments on proxy access
Appointments ☐		
Medication ☐		
Prospective ☐		
Retrospective ☐	Specify date / /	
All ☐		