

# Orchid House Surgery

## Registration form for 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/persons ..... 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	Date
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### Section 2

1. Online appointments booking	<input type="checkbox"/>
2. Online prescription management	<input type="checkbox"/>
3. Accessing the medication record for ..... ( <i>name of patient</i> )	<input type="checkbox"/>

### 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 will be responsible for the security of the information that I/we see or download	<input type="checkbox"/>
2. 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 type="checkbox"/>
3. If I/we see information in the record that is not about the patient or is inaccurate, I/we will contact the practice in writing as soon as possible. I will treat any information which is not about the patient as being strictly confidential.	<input type="checkbox"/>
4. I consent to have my user details communicated by email	<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	
First name		
Address		GP Name
Postcode		
Email address ( <i>please put in capital letters</i> )		
Telephone number		Mobile number

## The Representatives

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

Surname	Surname
First name	First name
Date of birth	Date of birth
Address	Address (tick if both same address) <input type="checkbox"/>
Postcode	Postcode
Email	Email
Telephone	Telephone
Mobile	Mobile

## For practice use only

The patient's NHS number		The patient's Emis ID number	
Identity verified by (initials)	Date	Method of verification Vouching <input type="checkbox"/> Vouching with information in record <input type="checkbox"/> Photo ID and proof of address <input type="checkbox"/>	
Proxy and medical record access authorised by:			
Date account created			
Date passphrase sent			
Level of record access enabled No Care Record Access <input type="checkbox"/> Core Summary Care Record <input type="checkbox"/> Partial Clinical Record <input type="checkbox"/> Detailed Coded Record <input type="checkbox"/>		Notes/comments on proxy access	