# OSWALD MEDICAL CENTRE

**PROXY ACCESS REQUEST FORM TO PATIENT ONLINE SERVICES**

**What is ‘Proxy Access’?**

Patients may choose to use Patient online services such as appointment booking, ordering repeat prescriptions or access to their records. They may choose to share their account credentials with family, friends and carers (including a care home) but as part of their access application they must be advised of the risks associated with doing this. Proxy access is the recommended alternative to sharing login details where a named individual is given their own set of login details for to access the records of another patient.

**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 applications will not be accepted from any third party commercial company i.e. Insurance company or solicitors.

**Proxy Access:** Parents may request a proxy access to their children’s records; access will reduce from age 11 and cease automatically when the child reaches the age of **16**. Any subsequent proxy access will need to be authorised by the patient subject to a Gillick competency test being completed with a clinician.

**Section 1**

I,………………………………………………….. (name of patient), give permission to my GP practice to give the following people:

**….………………………………………………………………..…………….. ……………….**

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 |

**Section 2**

|  |  |
| --- | --- |
| 1. Online appointments booking | 🞏 |
| 1. Online prescription management | 🞏 |
| 1. Access to medical records | 🞏 |

**Section 3**

I/we………………………………………………………………………….. (names of representative(s)) 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 | 🞏 |
| 1. I/we will be responsible for the security of the information that I/we see or download | 🞏 |
| 1. 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 | 🞏 |
| 1. 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 ALL Representative/s | Date/s |

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

|  |  |
| --- | --- |
| Surname: | Date of birth: |
| First name(s): | |
| Address: | |
| 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(s) | First name(s) |
| Address | Address |
| Email | Email |
| Telephone | Telephone |
| Mobile | Mobile |

Parents may request a proxy access to their children’s records; this will reduce and cease automatically when the child reaches the age of 16. Any subsequent proxy access will need to authorised by the patient subject to a competency test being completed.

Completing this form does not automatically guarantee access – the form will be passed to a GP or the Practice Manger for final authorisation where required.

*FOR PRACTICE USE ONLY*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Patient NHS number: | | | Patient EMIS number: | |
| Identity verified by (initials): | Date verified: | Method (record on EMIS):  ⃝ Vouching (known to staff)  ⃝ Vouching with information on record (at least 3 x checks required)  ⃝ Photo ID and proof of residence | | |
| Authorised by:   * GP * Practice Manager * Admin Lead / Reception Lead * Digital Champion | | Date authorised: | | |
| Date account created: |  | | | |
| Date credentials sent: |  | | | |
| Method by which they were sent: | USE POST | | | |
| Level of access granted:  (Grant prospective unless otherwise requested) | ⃝ Prospective  ⃝ Retrospective  ⃝ All  ⃝ Limited parts  ⃝ Contractual Minimum | | | Notes |