PARK GREEN SURGERY
Waters Green Medical Centre • Sunderland Street • Macclesfield • Cheshire • SK11 6JL
Tel: 01625 429555 • Fax: 01625 502950

CONSENT TO PROXY ACCESS TO GP ONLINE SERVICES

*Note: If the patient does NOT have capacity to grant proxy access and proxy access is considered to be in the patient's best interest, Section 1 of this form may be **omitted**.*

SECTION 1	
I, ______________________________ (patient name), give permission to Park Green Surgery 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.	
Signature of patient:	

SECTION 2	
1. Booking appointments	☐
2. Requesting repeat prescriptions	☐
3. Accessing the medical record for (patient name) ______________________________ *Subject to GP approval: Yes* ☐ *No* ☐	☐

SECTION 3	
I, ______________________________ (representative name), wish to have online access to the services ticked in the box above in Section 2 for ______________________________ (patient name). I understand my responsibility for safeguarding sensitive medical information and I understand and agree with each of the following statements.	
1. I agree that I will treat the patient information as confidential	☐
2. I will be responsible for the security of the information that I see or download	☐
3. I will contact the practice as soon as possible if I suspect that the account has been accessed by someone without my agreement	☐
4. If I see information in the record that is not about the patient, or is inaccurate, I 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.	☐
Signature of representative:	
Date:	

THE PATIENT (The person whose records are being accessed)	
SURNAME	
FIRST NAME	
DATE OF BIRTH	DD / MM / YYYY
ADDRESS	
POSTCODE	
GP NAME	
EMAIL ADDRESS	
HOME TELEPHONE	
MOBILE TELEPHONE	

THE REPRESENTATIVE (The person seeking access)	
SURNAME	
FIRST NAME	
DATE OF BIRTH	DD / MM / YYYY
ADDRESS	
POSTCODE	
EMAIL ADDRESS	
HOME TELEPHONE	
MOBILE TELEPHONE	
RELATIONSHIP TO PT	

FOR PRACTICE USE ONLY	
PATIENT NHS No:	PATIENT EMIS No:
IDENTITY VERIFIED BY (INITIALS): DATE:	METHOD OF VERIFICATION: ☐ VOUCHING ☐ VOUCING WITH INFO IN RECORD (E.G. POWER OF ATTORNEY) ☐ PHOTO ID AND PROOF OF RESIDENCE
PROXY ACCESS AUTHORISED BY:	DATE:
DATE A/C CREATED:	DATE PIN SENT:
LEVEL OF ACCESS ENABLED:	☐ NO CARE RECORD ACCESS ☐ CORE SUMMARY CARE RECORD ☐ PARTIAL CLINICAL RECORD ☐ DETAILED CODED RECORD
NOTES/COMMENTS:	