 **Formal Proxy Access Request Form**

**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 section1 of this form may be omitted.

**Consent to proxy access to GP online services**

Section 1 and 2 to be signed and completed by the patient

Section 3 to be signed and completed by the representative

**Section 1 - The Patient** (This is the person whose records are being accessed)

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

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 - Services**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Services** | **Description** | **Tick to grant access** |  |  |
| **Section A** | **Summary Care Record** |  |  |  |
| **Appointments** | Allows user to view and manage appointments online |  |  |  |
| **Repeat prescriptions** | Allows user to view and request repeat medications online |  |  |  |
| **Messaging** | Allows user to receive and send secure non–urgent messages with the practice |  |  |  |
| **Demographics** | Allows user to request an address change/update contact details online |  |  |  |
| **Section B** | **Detailed Medical Record** |  | **Date From** | **Date To** |
| **Test Results** | Allows user to view lab reports once seen and filed by the GP |  |  |  |
| **Documents** | Allows user to view letters and reports |  |  |  |
| **Immunisation** | Allows user to view vaccination and immunisation history |  |  |  |
| **Problems** | Allows user to see medical conditions |  |  |  |
| **Consultations** | Allows user to see the patient records written by the GP |  |  |  |
| **Share Record** | Enables user to share all or certain areas of their medical record for 24 hours using Patient Access |  | N/A | |
| **Section C** | **Full GP Record** | | | |
| **Access the full medical record** | Allows user to view the full medical record.  If no restrictions are specified, the user will be given access to all services.  *You can specify services and period of time below in Section B* |  |  |  |
| **Consent to speak to the practice regarding medical record** | |  |  | |
| **Please let us know if there are specific things in your record that you do not want to share:** | | | | |

**Section 3 - The Representative** (These are the people seeking proxy access to the patient’s online records, appointments or repeat prescription).

|  |  |
| --- | --- |
| **Representative 1** | **Representative 2** |
| Relationship to the patient  (Carer/Child/Family Member/Friend/Mother/Father) | Relationship to the patient  (Carer/Child/Family Member/Friend/Mother/Father) |
| Title | Title |
| First name | First name |
| Surname | Surname |
| Date of birth | Date of birth |
| Gender | Gender |
| Address  Postcode | Address (tick if both same address )  Postcode |
| Email | Email |
| Home Telephone | Home Telephone |
| Work Telephone | Work Telephone |
| Mobile | Mobile |
| Preferred communication method  (Email/Home/Work/Mobile) | Preferred communication method  (Email/Home/Work/Mobile) |
| Consent to receive SMS notifications  Yes/ No | Consent to receive SMS notifications  Yes/ No |
| Consent to receive email notifications Yes / No | Consent to receive email notifications  Yes / No |

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 |  |
| 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 of Representative 1 | Date |
| Signature of Representative 2 | Date |

**For practice use only**

|  |  |
| --- | --- |
| Patient’s NHS number | Patient’s Emis number |
| Identity verified by (initials) | Date |
| Method of verification of Patient   * Documentation Photo ID and Proof of Residence * Personal Vouching * Vouching with information in the patient record | Method of verification Representative(s)   * Documentation Photo ID and Proof of Residence * Personal Vouching * Vouching with information in the patient record |
| SNOMED 104 Code in patient record ☐ |  |
| Clinician | Date |
| Record Reviewed ☐ | Sensitive Information Redacted |
| Authorisation (Allow Access / Reject / Decide Later) | SNOMED 106 Code added to record ☐ |
| Notes/ comments on proxy access | Level of record access enabled    Prospective ☐  Retrospective ☐  All ☐  Limited parts ☐  Contractual minimum ☐ |
| Legal Basis Types   * Parental Responsibility (Under 16) * Patient not competent (Under 16) * Explicit Consent * Patient lacks capacity (Over 16)   **Patient Lacks Capacity:** In these circumstances, the four methods or recording the legal basis are:   1. Lasting power of Attorney for health and welfare 2. Court Appointed deputy 3. Best Interests 4. Clinician | Legal Basis Type: |
| Lasting power of attorney/ Court Appointed Deputy status verified ☐  [Registers held by the Office of the Public Guardian](https://www.gov.uk/government/publications/search-public-guardian-registers) | |
| Date account created |  |
| Date passphrase sent |  |

**Practice Codes**

|  |  |
| --- | --- |
| 882981000000105 | Consent given to share patient data with specified third party |
| 1364731000000104 | Enhanced review indicated before granting access to your own health record |
| 1364751000000106 | Enhanced review not indicated before granting access to your own health record’ applied. |