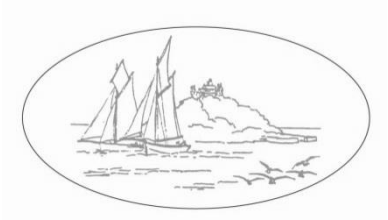
Marazion Surgery

Consent to proxy access to GP online services



Section 1

I,……..(name of patient), give permission to Marazion Surgery 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 Marazion Surgery.
- I have given the reasons why proxy access is required in section 2.

Signature of patient	Date

Section 2

1.	Online appointments booking	☐
	Reason:	
2.	Online prescription management	☐
	Reason:	
3.	Limited access to parts of the medical record for (name of patient)	☐
	Reason:	

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:

I/we have read and understood the information leaflet provided by the Practice and agree that I/we will treat the patient information as confidential	☐
I/we will be responsible for the security of the information that I/we see or download	☐
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	☐
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/we will treat any information which is not about the patient as being strictly confidential	☐

Signature/s of representative/s	Date/s

The patient

(This is the person whose records are being accessed)

Surname	Date of birth
First name	
Address & Post Code	
Email address	
Telephone number	Mobile number

The representative(s)

(These are the people seeking proxy access to the patient's online records, appointments or repeat prescription.)
Photographic identification of the representative(s) will need to be provided.

Surname	Surname
First name	First name
Date of birth	Date of birth
Address Postcode	Address Postcode
Email	Email
Telephone	Telephone
Mobile	Mobile
Identity Verified (complete separate slip if registered at the Practice; complete here if not registered at the Practice)	
Identity Verified by: Print name Signature Date	Method Photo ID and proof of residence

For Practice use only

Date account created	
Date passphrase sent	
Level of record access enabled All ☐ Prospective ☐ Retrospective ☐ Detailed coded record ☐ Limited parts ☐	This patient has capacity to authorise proxy access as requested
Level of access and capacity authorised by GP *GP Signature*	 *Date*