|  |
| --- |
| **Patient’s Details (To give consent for proxy access to their online record)** |
| Name:  | Date of Birth |
| Address: |
| **Consent** (To be completed by the person above unless lack of capacity because of medical condition) |

**I give consent for the person named below to have online access to:**

|  |  |  |
| --- | --- | --- |
| Book/cancel appointments for me | Yes | No |
| Request my repeat medication | Yes | No |
| View my core medical record (medications & allergies) | Yes | No |
| View the immunisations information in my care record | Yes | No |
| View test results in my care record | Yes | No |

**Signature of patient**: **…………………………………………………………….. Date: …………………………………………**

**OR**

Patient lacks capacity because of medical condition

*Please provide a copy of the legal paperwork (Power of Attorney/Court Appointed Deputy). If paperwork cannot be supplied then GP will need to confirm capacity before access is given.*

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| **Parent/Carer Details** (Requesting proxy access to online services for the patient named above)We need these details to be able to trace your existing online user account. |
| Family Name:  | Given Name: |
| Mr Mrs or …………. | Male/Female/or ………………………. | Date of Birth: |
| Address:  |
| Email address: ………………………………………………………………………………Consent to email registration details (if registered at another practice) |
| Relationship to the patient: Mother Father Carer Other …………………………… |
| Signature of parent/carer:  | Date: |

If you are registered with us, access will be added to your existing Online Services account – you will be able to switch to child/cared for person’s account via Linked Users (in drop down menu under your name). If you are registered elsewhere, we will email you the registration document you need in order to link your account to our practice patient.

**Confidentiality and Young people**

* Please note that access granted to a parent/guardian for a child aged 11-16, access will end once the child reaches 16 years.

|  |  |
| --- | --- |
| Signed by Parent/Guardian/Carer | Dated |
| ID checked Yes/No **ID is required for the patient and for the Proxy**Patient ID Document details Proxy ID Document Details1) 1)2) 2)ID Verified by: Date:  |