

**St Mary's Surgery**  
**37 St Mary's Street**  
**Ely**  
**Cambs**  
**CB7 4HF**

## Consent to proxy access to GP online services

### 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

Standard Access only – **ONE** form of ID required (see patient leaflet for details)

|                                |                          |
|--------------------------------|--------------------------|
| Online appointments booking    | <input type="checkbox"/> |
| Online prescription management | <input type="checkbox"/> |

### Section 3

Detailed Access request – **TWO** forms of ID required (see patient leaflet for details)

|  |                          |
|--|--------------------------|
| 3. Accessing the medical record for (name of patient): | <input type="checkbox"/> |
|--|--------------------------|

**A review of the medical records will be performed by a Clinician prior to Proxy/LPA access being granted. Please see practice procedure information attached**

I/we..... (names of representatives) wish to have online access to the services ticked in the box above in section 2 and 3

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   | <input type="checkbox"/> |
| I/we will be responsible for the security of the information that I/we see or download  | <input type="checkbox"/> |
| 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   | <input type="checkbox"/> |
| 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 | <input type="checkbox"/> |
| I/we have provided a copy of the LPA (if applicable)  | <input type="checkbox"/> |

|                                 |        |
|---------------------------------|--------|
| 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          |               |
| Postcode         |               |
| 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              | First name  |
| Date of birth           | Date of birth   |
| Address                 | Address (tick if both same address <input type="checkbox"/> ) |
| Postcode                | Postcode  |
| Email                   | Email   |
| Telephone               | Telephone   |
| Mobile                  | Mobile  |
| Relationship to Patient | Relationship to 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.

### Detailed medical records access procedure:

Patients/Proxy/LPA requesting advanced access will be notified, verbally or by letter, of the practices current time scales to grant detailed access to their record.

The practice, due to time required completing the review of applications and subsequent review of the patients' notes will process a set number of applications per month. Patients will be informed of this in relation to the time scale until access is granted.

Consideration will be given to information in the records that may cause distress or upset or be of a highly sensitive nature. Specific information can be withheld with reasonable explanation given to patients requesting advanced access.

Consideration will also be given to the patient's medical history and if access to their medical records is likely to cause significant harm as a result then either specific information can be withheld or in extreme cases, the application for access can be declined, with reasonable explanation.

3<sup>rd</sup> party information will not be shared. If 3<sup>rd</sup> party information is present within the notes, this will be removed until explicit consent has been gained from the 3<sup>rd</sup> party. Patients specifically requesting 3<sup>rd</sup> party information must submit a Subject Access Request.

## For practice use only

|                                 |      |                                       |   |
|---------------------------------|------|---------------------------------------|---|
| Patient's NHS number            |      | Patient's practice computer ID number |   |
| Identity verified by (initials) | Date | Method of verification                | Vouching <input type="checkbox"/><br>Photo ID <input type="checkbox"/><br>Photo ID and proof of residence |
| Copy of LPA received:           |      | YES / NO                              |   |
| Notes Required by:              |      | Date                                  |   |
| GP Authorisation:               |      | Date                                  |   |
| Date account created            |      |                                       |   |
| Date passphrase sent            |      |                                       |   |
| Notes / Reason for no capacity  |      |                                       |   |