**Maynard Court & Nazeing Valley Surgery**

**Online Services – Application/Consent Form for Proxy Access**

**Note**: If the patient does not have capacity to consent to grant proxy access and proxy access is considered by the patients named GP to be in their best interest Section 1 of this form may be omitted.

**The Patient**

|  |  |
| --- | --- |
| Surname: | First Name: |
| Date of Birth: | Email: |
| Telephone: | Mobile: |
| Address: |  |

**Section 1**

I give permission to my GP Practice to give the representative named below, proxy access to online services as indicated: \*Appointments and/or Prescriptions (\*please delete as appropriate)

* 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 |

**The Representative**

|  |  |
| --- | --- |
| Surname: | First Name: |
| Date of Birth: | Email: |
| Telephone: | Mobile: |
| Address: |  |
| Are you a patient at Maynard/Nazeing Valley Surgery?\*YES/NO (delete as appropriate) | Do you hold Power of Attorney for the patient?\*YES/NO (delete as appropriate)If “Yes”, please provide copy | Please state relationship, if any, to the patient. |

**Section 2**

I understand my responsibility for safeguarding sensitive medical information and I understand and agree with each of the following statements:

|  |  |
| --- | --- |
| 1. I have read and understood the information leaflet provided by the practice and agree that I/we will treat the patient information as confidential
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| 1. I will be responsible for the security of the information that I/we see or download
 | 🞏 |
| 1. I will contact the practice as soon as possible if I/we suspect that the account has been accessed by someone without my/our agreement
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| 1. If I 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 | Date |

**For practice use only**

|  |  |  |  |
| --- | --- | --- | --- |
| **Method of Verification:** | Vouching 🞏 | Vouching with info in Record 🞏  | Photo ID 🞏 |
| Identity verified by (name): | Date: |
| Proxy access authorised by (Must be a GP if Section 1 not completed):Name:Signature: | Date: |