Online Services Application for Proxy User Access (Age 0-11 years and Age 16+)

Rothschild House Group

PATIENT FOR WHICH ACCESS IS BEING REQUESTED					
Title		First Name		Last Name	
Gender				Date of Birth	
Address					

TO BE COMPLETED BY PATIENT			
I give permission to Rothschild House Surgery to give the below named individual/s proxy access to the online services as indicated below. 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 and I have read and understood the information leaflet provided by the practice.			
I grant permission to allow access to book appointments and order repeat prescriptions only			
I grant permission to allow access to book appointments, order repeat prescriptions and view online medical records.			
***Signature**		**Date**	
Name and relationship (if signed on behalf of patient)			

*if the patient does not have capacity to consent this should be signed by the person holding lasting power of attorney for health and welfare or by the GP.

PROXY USERS APPLYING FOR ACCESS					
Title		First Name		Last Name	
Gender				Date of Birth	
Address					
Email					
Relationship to Patient					
Title		First Name		Last Name	
Gender				Date of Birth	
Address					
Email					
Relationship to Patient					

TO BE COMPLETED BY THE PROXY USER/USERS APPLYING FOR ACCESS			
I/we understand my/our responsibility for safeguarding sensitive medical information and understand and agree with the following statements (please tick to indicate agreement):			
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 the patient's 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**		**Date**	
***Signature**		**Date**	

For surgery use only

Identity verified through (tick all that apply)	Vouching ☐ Vouching with information provided ☐ Photo ID ☐ Proof of residence ☐	Name of verifier	**Date**