The Beacon Health Group

Consent to proxy access to GP Online Services

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.

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.

Section 2

1. Online appointments booking	☐
2. Online prescription management	☐

- 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 patient

(This is the person whose records are being accessed)

Surname	
First name	
Date of Birth	
Address and Postcode	
Email address	
Home Telephone number	
Mobile Telephone 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	
Relationship to patient		Relationship to patient	
Address and Postcode	(tick if both at same address ☐)	Address and Postcode	
Email		Email	
Home Telephone		Home Telephone	
Mobile Telephone		Mobile Telephone	

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:

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	☐
2. I/we will be responsible for the security of the information that I/we see or download	☐
3. 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	☐
4. 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	☐
Signature/s of representative/s	
Date/s	

FOR PRACTICE USE ONLY – THIS FORM WILL NOT BE ACCEPTED UNLESS THE IDENLTITY OF THE PATIENT HAS BEEN VERIFIED.

The patient's NHS number	
Proof of ID of patient allowing proxy access to their record (Please give details of ID seen)	Photo ID ☐ Proof of residence ☐
Identity verified by	Name: Date: