**Application for Proxy User Access**

**Please complete this form and return via email to** [**istwulfstan@nhs.net**](mailto:istwulfstan@nhs.net)

**You will also need to include 2 forms of ID for both the patient granting permission and the proxy user. One form of ID needs to be photo ID and the other needs to be proof of address.**

**Application for Proxy User Access**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **TO BE COMPLETED BY THE PROXY USER APPLYING FOR ACCESS** | | | | | | | | | | | | |
| Title |  | | | First Name | |  | Last name | | |  | | |
| Gender | | Male/Female | | | | | Date of Birth | | |  | | |
| Address | | | |  | | | | | | | | |
| Email | | | |  | | | | | | | | |
| Relationship to Patient | | | | |  | | | | | | | |
| **I understand my responsibility for safeguarding sensitive medical information and understand and agree with the following statements *(please tick to indicate agreement):*** | | | | | | | | | | | | |
| I will be responsible for the security of the information that I see or download. | | | | | | | | | | | |  |
| I will contact the practice as soon as possible if I suspect that the account has been accessed by someone without the patient’s agreement. | | | | | | | | | | | |  |
| If I see information in the record that is not about the patient or is inaccurate, I will contact the practice as soon as possible, I will treat any information which is not about the patient as being strictly confidential. | | | | | | | | | | | |  |
| **Signature** | | |  | | | | | | | | | |
| **Date** | | |  | | | | | | | | | |
| **Patient for which access is being requested** | | | | | | | | | | | | |
| Title |  | | | First Name | |  | | Last name |  | | | |
| Gender | | Male/Female | | | | | | Date of Birth |  | | | |
| Address | | | |  | | | | | | | | |
|  | | | | | | | | | | | | |
| **TO BE COMPLETED BY THE PATIENT GRANTING PERMISSION FOR PROXY ACCESS\*** | | | | | | | | | | | | |
| **I give permission to St Wulfstan surgery to give the above named individual 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 is a child under 11 this should be signed by the Parent/Guardian**

**\*If the patient is assessed as lacking capacity this should be signed by the person holding lasting power of attorney for health and welfare. If there is no POA this should be left blank and the decision to grant access will be made by the GP.**

|  |  |  |  |
| --- | --- | --- | --- |
| **FOR OFFICE USE:** | | | |
| Existing Patient Access account located for proxy user/ New Patient Access account set up for Proxy user - PIN provided | | |  |
| Proxy user added to patient account |  | Date: Initials: | |