**PROXY ACCESS Online Registration Form**

**THIS FORM MUST BE COMPLETED BY THE PATIENT REPRESENTATIVE**

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 the form may be omitted.

**Section 1** (to be completed by the patient)

I …………………………………………….. (name of patient), give permission to my GP Practice to give the following person …………………………………………….. Proxy Access to the online service as indicated in section 2.

|  |  |  |
| --- | --- | --- |
| I reserve the right to reverse this decision 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**

## Please note: Signing this form will automatically opt you in to our Medication Request and Medical Records service. This means you will be able to request repeat medication and view your medical records online. If you wish to opt out of these services at any time, please call the practice

# To use our messaging facility please visit: <https://access.klinik.co.uk/contact/roxbourne-medical-centre> and select the ‘General Enquiries’ tab.

**Section 3** (to be completed by the representative)

I ………………………………………… (name of representative) wish to have online access to the services ticked in section 2 for …………………………………………………….. (name of patient).

I understand my responsibility to safeguard sensitive medical information and I understand and agree with each of the following statements (please tick):

|  |  |  |
| --- | --- | --- |
| 1. I have read and understood the information leaflet provided by the practice (and the information contained with this form) and agree that I will treat the patient information as confidential | |  |
| 1. I will be responsible for the security of the information that I can see | |  |
| 1. I will contact the practice as soon as possible if I suspect that the account has been accessed by someone without my agreement | |  |
| 1. If I use a shared email address, I am aware others will be able to see the records/ appointments and medications. This is at my own risk | |  |
| 1. If I can 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 | |  |
| 1. I have provided the verification (ID) details as requested by the Practice | |  |
| Signature of the Representative: | Date: | |

**Section 4**

**Patient Details** (this is the person whose records are being accessed)

|  |  |
| --- | --- |
| Title: | Mr/ Mrs/ Miss/ Ms/ Master |
| First Name: |  |
| Last Name: |  |
| Date of Birth: |  |
| Address: | Postcode: |
| Contact Number(s): |  |
| Email Address: |  |

**Representative Details** (this is the person seeking proxy access to the record)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Title: | Mr/ Mrs/ Miss/ Ms/ Master | | | |
| First Name: |  | | | |
| Last Name: |  | | | |
| Date of Birth: |  | | | |
| Address: | Postcode: | | | |
| Contact Number(s): |  | | | |
| Email Address: |  | | | |
| Relationship to patient: | Carer |  | Friend |  |
| Child |  | Mother |  |
| Family member |  | Father |  |
| PLEASE ENSURE A CONSENT FORM HAS BEEN PROVIDED ALONG WITH THIS FORM IF THE PATIENT IS OVER 11 YEARS OF AGE AND IS BELIEVED TO HAVE CAPACITY TO CONSENT | | | | |

### For practice use only

|  |  |  |
| --- | --- | --- |
| The patient’s NHS number | The patient’s EMIS number | |
| Identity verified by (initials) | Method of verification:  Vouching 🞏  Vouching with information in record 🞏  Photo ID 🞏 | Date |
|  | | |
| Proxy Access authorised by GP Principal: | Additional Notes about Access | Date |
| Date account created | Level of record access enabled:  Appointments 🞏  Repeat prescriptions 🞏  Messaging 🞏  Medical record 🞏 | |