**Application for Proxy User Access**



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| **Patient’ s Details** | | | | | | | | | | | |
| Title |  | | | First Name |  | | Last name | | |  | |
| Gender | | Male/Female | | | | | Date of Birth | | |  | |
| Address | | | |  | | | | | | | |
| **TO BE COMPLETED BY PATIENT** | | | | | | | | | | | |
| **I give permission for CGH Partnership to give the below 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 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.**

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| **Proxy User applying for access** | | | | | | | |
| Title |  | | First Name | |  | Last name |  |
| Gender | | Male/Female | | | | Date of Birth |  |
| Address | | |  | | | | |
| Email | | |  | | | | |
| Relationship to Patient | | | |  | | | |

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| --- | --- | --- | --- | --- |
| **TO BE COMPLETED BY THE PROXY USER APPLYING FOR ACCESS** | | | | |
| **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 and treat any information which is not about the patient as strictly confidential. | | | |  |
| **Signature** |  | **Date** |  | |
| **Signature** |  | **Date** |  | |

|  |  |
| --- | --- |
| Identity verified by (print full name):  Checked by (print full name): | Photo ID seen (state what ID has been seen) |
| Proof of Residence (state what document has been seen) |
| Authorised by: | Date: |