Bournbrook Varsity Medical Centre

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**Tel: 0121 472 0129**

***Open Monday to Saturday***

***Dr C Allen, Dr M Swallow, Dr A Dungate, Dr S Clarke - Partners***

***Dr M Philp, Dr A Nijjar, Dr H Cole, Dr S Ali, Dr J Tatlock, Dr N Ahmad, Dr N Grant, Dr H Sukkar – Associates***

# 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 practice to be in the patient’s best interest, section 1 of this form may be omitted.**

**If you are making a proxy access application to access the medical records of a child, we will need to see evidence of parental responsibility.**

**Section 1 – Request**

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.

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 terms and conditions provided by the practice

|  |  |
| --- | --- |
| **Signature of Patient** | **Date** |

## Section 2 - Access to Records

|  |  |
| --- | --- |
| Booking Appointments |  |
| Requesting Repeat Prescriptions |  |
| Accessing the Medical Records |  |

**Section 3 – Declaration**

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 |  |
| 1. I/we will be responsible for the security of the information that I/we see or download |  |
| 1. 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 |  |
| 1. If I/we see information in the record that is not about the patient, or is inaccurate, I/we will contact the practice, in writing, as soon as possible. I will treat any information which is not about the patient as being strictly confidential |  |

|  |  |
| --- | --- |
| **Signature of representative(s)** | **Date** |

**Section 4 – The Patient (The person who’s records are being accessed)**

|  |  |
| --- | --- |
| **Surname** | **First Name** |
| **Date of Birth** | |
| **Address**  **Postcode** | |
| **Email Address** | |
| **Telephone Number** | **Mobile Number** |

**Section 5 - The Representative - 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** |
| **Address** | **Address (**tick if both same address 🞏) |
| **Postcode** | **Postcode** |
| **Email** | **Email** |
| **Telephone** | **Telephone** |
| **Mobile Number** | **Mobile Number** |

**For Practice Use Only**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Patients NHS Number** | | **Practice Computer ID Number** | | | |
| **Identity Verified by**  **(initials only)** | **Date** | | **Method of Verification**  **Vouching** 🞏  **Vouching with information in record** 🞏  **Photo ID and proof of residence** 🞏 | | |
| **Proxy Access Authorised By** | | | | | **Date** |
| **Date Account Created** | | | | | |
| **Date passphrase sent** | | | | | |
| **Level of Record Access Enabled**  **Prospective 🞏**  **Retrospective 🞏**  **All 🞏**  **Limited parts 🞏**  **Contractual minimum 🞏** | | | | **Notes / Comment(s) on Proxy Access** | |