# The Muswell Hill Practice

**Consent to proxy access to GP online services**

**Section 1: The patient**

(This is the person whose records are being accessed)

|  |  |
| --- | --- |
| Surname | Date of birth |
| First name |
| Address  Postcode  |
| Email address |
| Telephone number | Mobile number |

**Section 2: What access you would like your proxy to see online**

|  |  |
| --- | --- |
| Online appointments booking | 🞏 |
| Online prescription management | 🞏 |
| Allergies and medication | 🞏 |
| Immunisations | 🞏 |
| Test Results | 🞏 |
| Documents | 🞏 |
| Problems | 🞏 |
| Consultations | 🞏 |

**Section 3: Patient Consent**

If aged 11 or over, please sign to confirm you give permission for the people in section 4 to have access to your records as indicated above 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.*

|  |  |
| --- | --- |
| Signature of patient | Date |

**Section 4: The representatives**

(These are the people seeking proxy access to the patient’s records)

|  |  |
| --- | --- |
| Surname | Surname |
| First name | First name |
| Date of birth | Date of birth |
| AddressPostcode  | Address (tick if both same address 🞏)Postcode |
| Email (write clearly) | Email (write clearly) |
| Telephone | Telephone |
| Mobile | Mobile |

**Section 5: Declaration**

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 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 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 |

**Please email this form to** **nclicb.tmhp.registrations@nhs.net** **with a copy of photo ID for each representative in Section 2 of the form.**