**St Mary Street Surgery**

**Application for Proxy Access to a Child’s Online Account**

**(For children aged 11 years and under)**

* To obtain online proxy access the parent/guardian must also be registered for online access at the practice.
* Only **one** parent/guardian may request online proxy access.
* The parent/guardian must show photo ID **and** proof of parental responsibility (original birth certificate not a photocopy).
* Online proxy access granted to the parent/guardian will reduce at the age of 11 and end once the child reaches 16 years old. The young person should then complete and sign a new consent form (Form A) if they wish their parent/guardian to continue to have full online proxy access to their medical record.

**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**

Please tick which type of online access is required. *\*Please note restricted view is in place*

|  |  |
| --- | --- |
| Laboratory Test Results |  |
| Documents |  |
| Immunisations |  |
| Consultations |  |
| Problems |  |
| Booking GP Appointments |  |
| Requesting Repeat Prescriptions( you cannot request acute or past medications) |  |
| Allergies |  |

**Section 3**

**The Representative**

*This is the person who is seeking online proxy access to the patient’s medical record*

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

I, ……………………………………………………………………………………………

…………………………………………………………………………………………………

(name of representative) wish to have proxy access to the online services ticked in the box above in section 2 for

………………………………………………….……………………………… (name of patient).

I understand my responsibility for safeguarding sensitive medical information and I understand and agree with each of the following statements:

|  |  |  |
| --- | --- | --- |
| 1. | I have read and understood the Patient Information leaflet provided by the practice and agree that I will treat the patient’s information as confidential |  |
| 2. | I will be responsible for the security of the information that I see or download |  |
| 3. | I will contact the practice as soon as possible if I suspect that the online access account has been accessed by someone else without my/the patient’s prior agreement |  |
| 4. | If I see information in the medical 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 in strict confidence |  |

|  |  |
| --- | --- |
| Signature of Representative | Date |

**For Practice use only**

Photo ID must be seen of the Representative and proof of parental responsibility e.g. original birth certificate of child

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| The Patient’s NHS number | | | Emis Number | | |
| Identity verified by (initials) | Date | Method of verification    Photo ID ( Drivers Licence or Passport) |  | Rep    ­­­ |  |
| Original Birth Certificate Seen | | Yes/No | | | |
| Online proxy access linked | | Yes/No | | | |
| Date | | Proxy access authorised by | | | |