



Application for Proxy User Access

(e.g. Children under 16 years of age/carers/family members)

Patient for which access is being requested				
Title		First Name		Last name
Gender	Male/Female			Date of Birth
Address				

TO BE COMPLETED BY PATIENT				
<p>I give permission to Poplar Grove Practice to give the below named individual/s proxy access to the online services as indicated below.</p> <p>I reserve the right to reverse any decision I make in granting proxy access at any time.</p> <p>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.</p> <p>I am aware that any dispute at any time over my signature will be passed to the NHS Fraud Department.</p>				
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. {Proof of PoA must be seen and copied by Poplar Grove Practice.}**

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

TO BE COMPLETED BY THE PROXY USER APPLYING FOR ACCESS				
<p>I understand my responsibility for safeguarding sensitive medical information and understand and agree with the following statements (<i>please tick to indicate agreement</i>):</p>				
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/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				Date

FOR OFFICE USE:				
Existing Patient Access account located for proxy user/ New Patient Access account set up for Proxy user - PIN provided				
Proxy user added to patient account		Date:		Initials: