Application for Proxy User Access

Children under 16 years of age.

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

TO BE COMPLETED BY PATIENT	
I give permission to Poplar Grove Practice to give the below named individual/s 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 am aware that any dispute at any time over my signature will be passed to the NHS Fraud Department.	
I grant permission to allow access to book appointments and order repeat prescriptions only	☐ **11-16 years**
I grant permission to allow access to book appointments, order repeat prescriptions and view online medical records	☐ **Under 10 years Only**

***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	
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/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: