Thurleigh Road Practice

Proxy Online Access Application Form for 0-10 year old ONLY

Notes:

- The Person(s) seeking proxy online access must be registered as a patient with Thurleigh Road Practice, and have their own online access.
- As a parent/guardian, you will need you to confirm your parental rights.

Section 1. Patient Details.

Surname	Date of Birth
First Name	
Address	
Mobile No:	Telephone No:

Section 2. Access type Requested

I/We wish to have access to the following online services for the above named child **(Please Tick)**

1. Book appointments	
2. Request repeat prescriptions	
3. View Medical records	
4. View Demographic information	

Section 3. Proxy Access Requestors. (Who is/are seeking proxy access as indicated in Section 2.)

1	Surname	Date of Birth
	First Name	Relationship to the Patient (Child):
	Address	
	Email address:	
	Mobile No:	Telephone No:
2	Surname	Date of Birth
	First Name	Relationship to the Patient (Child):
	Address	
	Email address:	
	Mobile No:	Telephone No:

Section 4. Requestor's Acknowledgement.

As a parent/guardian I confirm that I have parental/guardianship responsibility for the above named child.. At least one of the following must apply and your parental rights must not have been removed by the courts. Please tick to indicate which applies:

(Please Tick)

	Your name is on the Birth Certificate OR
	If you are the father, you were married to the mother at the time of birth OR
	You have been granted parental rights by the Courts OR
	If you are the father, you have the agreement of the mother
AND	
	My parental rights have not been removed by the Courts

Signature of Parent/Guardian:	Date:
Signature of Parent/Guardian:	Date:

I/we named in Section 3, (parents/guardian) wish to have online access to the services as mentioned 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:

	(Please Tick)
1. I/we have read and understood the 'patient information leaflet for online access' provided by the practice	
2. I/we will be responsible for the security of the information that I/we see or download	
3. 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.	
4. 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	
5. I/we certify that I/we am/are the parent or legal representative of the child listed on this form and that all information I have provided is correct. I hereby request access to the above named patient's online account.	

1. Signature of Parent/Guardian:	Date:
2. Signature of Parent/Guardian:	Date:

Please note: all online access will be revoked once the patient reaches 11 year old.

For Practice use only

<table>
<tr><td colspan="3">Patient EMIS number</td></tr>
<tr><td>Identity verified by (initials)</td><td>Date</td><td>Method
Birth certificate ☐
Vouching ☐
Vouching with information in record ☐
Photo ID and proof of residence (tick below)
Passport ☐
Driving license ☐
Bank statement ☐
Other (please record) ☐</td></tr>
<tr><td colspan="3">Date account created</td></tr>
<tr><td colspan="3">Date passphrase sent</td></tr>
<tr><td colspan="3">Date record access enabled</td></tr>
<tr><td colspan="2">Level of record access enabled
No record access ☐
Core summary (medications and allergies) ☐
Detailed coded records access ☐ Specify below:
<table>
<tr><td>Read coded data</td><td></td></tr>
<tr><td>Immunisations</td><td>☐</td></tr>
<tr><td>Lab test results</td><td>☐</td></tr>
<tr><td>Problems</td><td>☐</td></tr>
<tr><td>Consultations</td><td>☐</td></tr>
<tr><td>Allergies</td><td>☐</td></tr>
<tr><td>Medication</td><td>☐</td></tr>
</table></td><td>Notes / explanation</td></tr>
</table>

Please scan completed and actioned form to medical records