Patient access NHS England

Thurleigh Road Practice

Proxy Online Access Application for 11-15 years 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.
- If the patient (child) does not have the capacity to consent to proxy access, and proxy access is considered by the practice to be in the patient's best interest, *section 2* of this form may be omitted.
- As a parent/guardian, you will need you to confirm your parental rights. If your child is capable and able to understand the implications of your access, they we need to give their consent even though they are under 16 years of age.
- The Patient (child) must sign the form in the presence of Thurleigh Road Practice Staff.

Section 1 – Patient Details

Surname	Date of Birth dd/mm/yyyy
First Name	
Address	
Email address:	
Mobile No:	Telephone No:

Section 2 – Consent Details

I, the above named Patient, give consent for the people named in Section 3 to be granted Proxy Online Access to my patient records to allow them to do the following.

	(Please Tick)
1. Book appointments	
2. Request repeat prescriptions	
3. View Medical records	
4. View Demographic Information	

Signature of Patient (Child):	Date:
Witnessed by TRP staff: (Full Name & Signature)	Date:

Section 3 – Proxy Access Requestors (This is who will be granted online as detailed in Section 2)

1	Surname	Date of Birth dd/mm/yyyy
	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:

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Section 4 – Parent/Guardian Acknowledgement

I/we the parent(s)/guardian(s) named in *Section 3,* wish to have online access to the services ticked in the box above 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 named 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:

<u>Please note: all online access will be revoked once the patient turns 16, or when the patient revokes the access rights given to the Requestors.</u>

For Practice use only

Patient EMIS number		
Identity verified by (initials)	Date	Method Vouching ☐ Vouching with information in record ☐ Photo ID ☐
Date account created		
Date passphrase sent		
Date record access enabled		

Level of record access enabled No record access ☐ Core summary (medications and allergies) ☐ Detailed coded records access ☐ Specify below:	Notes / explanation

Read coded data	
Immunisations	☐
Lab test results	☐
Problems	☐
Consultations	☐
Allergies	☐
Medication	☐

Please scan completed and actioned form to medical records