

Online Proxy Access Request form

To be completed by patient

Surname:	Date of birth:
First name:	Age:
Email:	Telephone number:

ACCESS I WISH TO BE GRANTED TO THE PERSONS NAMED OVERLEAF

Booking my appointments	<input type="checkbox"/>
Requesting my repeat prescriptions	<input type="checkbox"/>
Updating my contact details (demographics)	<input type="checkbox"/>
Secure online access to my full electronic GP record	<input type="checkbox"/>

PATIENT CONSENT

- I hereby give permission to my GP practice to give the person listed below access to the above-indicated online services on my behalf and act as my proxy
- I reserve the right to reverse any decision I make in granting this access at any time
- I understand the risks of allowing someone else to have proxy access to my health records, following my authorisation

Signature: <i>Must be signed by patient if 13yrs or older</i>	Date:
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If the patient is over 13yrs old and unable to sign or provide informed consent to allow proxy access, please indicate why this is not possible, whether LPA is in force etc.:

To be completed by Proxy

****You must be a patient of Lightwater Surgery and registered for online services to manage someone else's medical details on the NHS App****

- I will be responsible for the security of the information that I see or download
- If I choose to share information with anyone else, this is at my own risk
- I will contact the practice as soon as possible if I suspect that this account has been accessed by someone without my agreement
- If I see information in the record that is not about the patient or inaccurate, I will contact the practice as soon as possible

Full Name:	
DOB:	
Address:	
Tel. No:	
Email address:	
Relationship to patient:	
Signature of proxy:	
Date:	

Reception use: PHOTOGRAPHIC ID REQUIRED FOR EITHER OF THE NAMED PERSONS

Full name on ID:	
Reference number and exp date:	
Staff member checked & accepted:	