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Consent to proxy access to GP online services for Children between the ages of 11 and 15

Note: As part of national guidance once the child has reached the **Age of 11**, a child's Proxy Access will automatically be removed and will need to be reapplied for. For full information concerning this please go onto our website www.jth.org.uk/proxy-access-for-children

Section 1 - The Patient

(This is the person whose records are being accessed)

First name	
Surname	Date of birth
Address	
Postcode	
Email address	
Telephone No(s):	

Section 2 - Access Levels (Note: Immunisation records will automatically be activated, if additional levels of access are required – please select from the list below)

1. Online prescription management ONLY	☐
2. Accessing the medical record for "**The Patient**"	☐

Section 3 - The Representatives

(These are the persons seeking proxy access to the patient's online records, appointments or repeat prescriptions.)

Relationship to patient:	Relationship to patient:
Surname	Surname
First name	First name
Date of birth	Date of birth
Patient at this Surgery Yes ☐ No ☐	Patient at this Surgery Yes ☐ No ☐

Section 3 - The Representatives (cont'd)

(*tick if the same address* as **The Patient** ☐)

Address	Address (tick if both same address ☐)
Postcode	Postcode
Email	Email
Tel No:	Tel No:

The **"Representative(s)"** wish to have online access to the services ticked in the box in **Section 2**

I/we understand my/our responsibility for safeguarding sensitive medical information, and I/we understand and agree with each of the following statements:

1. I/we have read and understood the information online provided by the practice and agree that we/I will treat "**the Patient"** information as confidential	☐
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. I will treat any information which is not about **"the Patient"** as being strictly confidential	☐

Signature representative (1)	Signature representative (2)	Signature of Patient (Child)
Name:	Name:	Name:
Surgery Witness	Surgery Witness	Surgery Witness for child

NB: This request WILL NOT be processed unless the representative(s) sign form.

Surgery Checklist

☐ **Proof of ID**

CHILD: Passport, Birth Certificate or Photo ID

☐ **Parental / Guardian responsibility**

ADULT: Passport, Driving License, Birth Certificate or other appropriate documentation

Further info: https://www.medicalprotection.org.uk/articles/eng-parental-responsibility

For practice use only – ONLINE ACCESS TEAM		
Date account created	Date login credentials sent	Admin (initials)
Passed to GP (if necessary) ☐	'Gillick competent for consent [XaKIJ]' ☐	'Not Gillick competent for consent [XaXLv]' ☐