

John Tasker House and Felsted Surgeries

56 New Street, Dunmow, Essex CM6 1BH
Telephone: 01371 872121

www.jth.org.uk
VAT Number 711670949

Braintree Road, Felsted, CM6 3DL
Telephone: 01371 820410

*Dr D Tideswell, Dr T Robson, Dr Jo Ward, Dr Tania Brasse & Dr Ben Seaman
Associate GPs – Dr Jackie Stevens, Dr Thidar Myint, Dr Katy-Ellen Disley & Dr Vernetta Buffong*

Consent to proxy access to GP online services (Adults only)

Note: If the patient does not have capacity to consent to grant proxy access and therefore considered by the practice to be in the patient's best interest "**The Patient's**" authority may be omitted.

It is an NHS requirement that once the child has reached the **Age of 16**, a child's Proxy Access will automatically be removed and the patient is required to create their own NHS Online.

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):	

"**The Patient**", gives permission to the GP practice to provide the **Representative(s)** on this application for proxy access to the online services - Access Levels as indicated below in **Section 2**.

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.

I have read and understand the information provided online by the practice.

Signature of patient	Date
----------------------	------

Section 2 - Access Levels

1. Online prescription management ONLY	<input type="checkbox"/>
2. Accessing the medical record for " The Patient " *	<input type="checkbox"/>

Please give reason for Proxy request (must be completed) and * state why it is necessary for access to medical records, if requested

--

Section 3 - The Representative(s)

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

First name	First name
Surname	Surname
Date of birth	Date of birth
Address	Address (tick if both same address <input type="checkbox"/>)
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	<input type="checkbox"/>
2. I/we will be responsible for the security of the information that I/we see or download	<input type="checkbox"/>
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	<input type="checkbox"/>
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	<input type="checkbox"/>

Signature/s of representative/s	Date
---------------------------------	------

For practice use only – **GP AUTHORITY**

GP Name and signature	Tick appropriate YES <input type="checkbox"/> NO <input type="checkbox"/>	
Date		
Reason for refusal if record access is refused.		
For practice use only – ONLINE ACCESS TEAM		
Date account created	Date login credentials sent	Admin (initials)