**Application for Proxy User Access**

Children (under 11) & Adults lacking capacity

**Please complete and email back to istwulfstan@nhs.net with copies of two forms of ID from the person applying for proxy access: one form of photo ID and one proof of address**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **TO BE COMPLETED BY THE PROXY USER APPLYING FOR ACCESS** | | | | | | | | | | | | |
| Title |  | | | First Name | |  | Last name | | |  | | |
| Gender | | Male/Female | | | | | Date of Birth | | |  | | |
| Address | | | |  | | | | | | | | |
| Email | | | |  | | | | | | | | |
| Relationship to Patient | | | | |  | | | | | | | |
| **I understand my responsibility for safeguarding sensitive medical information and understand and agree with the following statements *(please tick to indicate agreement):*** | | | | | | | | | | | | |
| I will be responsible for the security of the information that I see or download. | | | | | | | | | | | |  |
| I will contact the practice as soon as possible if I suspect that the account has been accessed by someone without the patient’s agreement. | | | | | | | | | | | |  |
| If I see information in the record that is not about the patient or is inaccurate, I will contact the practice as soon as possible, I will treat any information which is not about the patient as being strictly confidential. | | | | | | | | | | | |  |
| **Signature (can by typed)** | | |  | | | | | | | | | |
| **Date** | | |  | | | | | | | | | |
| **Patient for which access is being requested** | | | | | | | | | | | | |
| Title |  | | | First Name | |  | | Last name |  | | | |
| Gender | | Male/Female | | | | | | Date of Birth |  | | | |
| Address | | | |  | | | | | | | | |
| **Level of access being applied for:** | | | | | | | | | | | | |
| Access to book appointments and order repeat prescriptions only | | | | | | | | | | |  | |
| Access to book appointments, order repeat prescriptions and view online medical records | | | | | | | | | | |  | |

Please note: by typing name or adding an electronic signature, you confirm that St Wulfstan Surgery accepts the validity of this form.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **FOR OFFICE USE:** | | | | | | |
| **Reception:** | | | | | | |
| Identity verified by (initials) | |  | | Date: |  | |
| **GP: Please indicate level of access and sign to approve** | | | | | | |
|  | Access to appointments & prescriptions only | | | | | |
|  | Access to appointments, prescriptions and online medical records | | | | | |
|  | Access not approved | | | | | |
| Signature: Date: | | | | | | |
| **Admin:** | | | | | | |
| Proxy user added to patient account Date: | | | Initials: | | |  |
| Email sent to proxy user Date: | | | Initials: | | |  |