# Proxy Access Application Form B

# For cared for patients aged 11 years and over

**Cared for Patient’s Details** (*To give consent for proxy access to their online services)*

|  |  |  |
| --- | --- | --- |
| Name: |  | Date of Birth: |
| Address: | | |

**Consent** (to be completed by the person named above unless lacks capacity because of medical condition)

**I give consent for the person named below to have online services access to:**

|  |  |  |
| --- | --- | --- |
| Book/cancel appointments for me | Yes | No |
| Request my repeat medication | Yes | No |
| View my core medical record (test results, consultations, allergies, medication etc) | Yes | No |
| View the immunisations information in my care record | Yes | No |
| View test results in my care record | Yes | No |

|  |  |
| --- | --- |
| Signature of patient: | Date: |

***OR***

**Patient lacks capacity to consent because of medical condition**

Please provide copy of legal paperwork (Power of Attorney/Court Appointed Deputy). If paperwork cannot be supplied then GP will need to confirm incapacity before access is given. **\*\*See back sheet\*\***

**Parent/Carer Details** (Requesting proxy access to online services for the patient named above)

*We need these details to be able to trace your existing online user account*

|  |  |  |  |
| --- | --- | --- | --- |
| Family Name: |  | Given Name: | |
| Mr  Mrs  or ………………. | Male  Female  or …………….….. | | Date of Birth: |
| Address: | | | |
| Registered at: Beechwood Medical Practice  Other Practice  …………………………………….. | | | |
| Email address:  Consent to email registration details  (*if registered at another practice)* | | | |
| Relationship to patient above: Mother  Father  Carer  Other family member ……………… | | | |

|  |  |
| --- | --- |
| Signature of parent/carer: | Date: |

***TURN OVER FOR ID AND PAPERWORK CHECK***

# ------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

# Identity Verification: Practice use only *(staff member to complete when giving registration details to patient)*

|  |  |
| --- | --- |
| **Identity verified by**  Staff Member Name:……………………..  Signature:………………………………... | Responsibility for patient verified  Parent/Carer ID seen  Lasting Power of Attorney paperwork seen, and copy taken –  please attach to this document    GP required to confirm patient lacks capacity as  documentation not available |

***Please hand this form to reception – if your request is not actioned within 1 week then please contact us***

If you are registered with us, access will be added to your existing Online Services account – you will be able to switch to child/cared for person’s account via Linked Users (in drop-down menu under your name). If you are registered elsewhere, we will email you the registration document you need in order to link your account to our practice patient.