**Cross Deep Surgery**

**PROXY Application Form for Online Access**

**\*\* Access to Appointments and Prescriptions ONLY \*\***

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| **Patient Details (person whose record will be accessed)** | | | |
| Surname |  | Date of birth | |
| First name | | | |
| Address | | | Postcode |
| Email address | | | |
| Telephone number |  | Mobile number | |
| Please read the below confirm that you have read and understood the following statements:   * 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 will be responsible for the security of my account, and the information that I see or download If I choose to share my information with anyone else, this is at my own risk * If I suspect that my account has been accessed by someone without my consent, I will inform the practice as soon as possible * If I see information in my record that is not about me or is inaccurate, I will inform the practice as soon as possible * If I think that I may come under pressure to give access to someone else unwillingly I will inform the practice as soon as possible * The practice reserves the right to terminate access at any point if it is thought that it is in the best interests of the patient or if the services are being misused     🞎 TICK HERE IF THE PATIENT DOES NOT HAVE CAPACITY TO GRANT PROXY ACCESS. ACCESS WILL BE GRANTED BY THE PRACTICE IF IT IS CONSIDERED TO BE IN THEIR BEST INTERESTS  I Agree to give access to my Patient Access Online Account to the below Proxy and understand and agree  Signed by or on behalf of the patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |

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| **Proxy Detail (person who will be accessing the record)** | | | |
| Surname |  | Date of birth | |
| First name | | | |
| Address | | | Postcode |
| Relationship to Proxy Access: | | | |
| Email address: | | | |
| Telephone number |  | Mobile number | |
| Please read the below confirm that you have read and understood the following statements:   * I will treat patient information as fully confidential * I will be responsible for the security of this account, and the information that I see or download * If I suspect that the account has been accessed by someone without the patients consent, I will inform the practice as soon as possible * If I see information in the record that is not about the patient or is inaccurate, I will inform the practice as soon as possible * If I think that I may come under pressure to give access to someone else unwillingly I will inform the practice as soon as possible * The practice reserves the right to terminate access at any point if it is thought that it is in the best interests of the patient or if the services are being misused   Signed by Proxy User:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |

*For practice use only*

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| Identity verified and password created by | | Date | | Photo ID and proof of residence  Vouching |
| Level of Access Enabled (tick) | | | | |
| Appointment Booking |  | |
| Prescription ordering |  | |
| Access authorised by  Date | | |
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Updated 18/08/2020