**Dr Alistair Adey**

**BSc MBBS DRCOG MRCGP**

**Dr Julia Dancy**

**MBChB MRCP MRCGP DCH DTM&H DFFP**

**Dr Edward Argent-Belcher**

**MA (Cantab) MB BChir MRCGP**

**Dr Rachel Callely**

**MBBS MRCP MRCGP**

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**DRS ADEY & DANCY**

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**Consent to proxy access to GP online services**

**Note**: If the patient does not have capacity to consent to grant proxy access and proxy access is considered by the practice to be in the patient’s best interest section 1 of this form may be omitted.

**Section 1**

I,………………………………………………….. (name of patient), give permission to Drs Adey & Dancy to give the following individual ….………………………………………………………………..……………..

proxy access to the online services 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 leaflet provided by the practice

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

**Section 2**

|  |  |
| --- | --- |
| 1. Online appointments booking | 🞏 |
| 1. Online prescription management | 🞏 |
| 1. Accessing the medical record for (name of patient) | 🞏 |

**Section 3**

I…………………………………………………………………………….. (name of representative) wish to have online access to the services ticked in the box above in section 2

for ……………………………………….……… (name of patient).

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

|  |  |
| --- | --- |
| 1. I have read and understood the information leaflet provided by the practice and agree that I will treat the patient information as confidential | 🞏 |
| 1. I will be responsible for the security of the information that I/we see or download | 🞏 |
| 1. I will contact the practice as soon as possible if I/we suspect that the account has been accessed by someone without my/our agreement | 🞏 |
| 1. 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 of representative | Date |

**The Patient** (This is the person whose records are being accessed)

|  |  |
| --- | --- |
| Surname | Date of birth |
| First name | |
| Address  Postcode | |
| Email address | |
| Telephone number | Mobile number |

**The Representative**

(The person seeking proxy access to the patient’s online services).

|  |
| --- |
| Surname |
| First name |
| Date of birth |
| Address  Postcode |
| Email |
| Telephone |
| Mobile |

**For practice use only**

|  |  |  |  |
| --- | --- | --- | --- |
| The patient’s NHS number | | Patient’s EMIS ID Number | |
| Identity verified by  (initials) | Date | Vouching 🞏  Vouching with information in record 🞏  Photo ID and proof of residence 🞏 | |
| Proxy access authorised by | | | Date |
| Date account created | | | |
| Date passphrase sent | | | |
| Level of record access enabled    Appointments, Prescriptions & Summary 🞏 Medical record 🞏 | | Notes / comments on proxy access | |