# Forest House Medical Centre & Warren Lane Surge

# Application for under 14 years online account & Proxy Access for ALL PATIENTS

|  |  |
| --- | --- |
| Proxy User Surname: | Date of birth: |
| Proxy User First name: NHS Number: | |
| Address:  Postcode: | |
| Email address: Mobile number: | |

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

D. O. B: \_\_\_ \_\_\_ / \_\_\_ \_\_\_ /\_\_\_ \_\_\_ \_\_\_ \_\_\_ NHS Number: \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_­

Reason for proxy access (Please provide any court order or POA)

|  |  |
| --- | --- |
| Parent Request (access will be removed when child is 14 years old) |  |
| Patient Request |  |
| Patient lacks Capacity – Court Order |  |
| Patient lacks Capacity – Power of Attorney |  |
| Patient lacks Capacity – Patient’s best Interest (with GPs agreement) |  |

Please tick what you would like to have access to

|  |  |
| --- | --- |
| I wish to have access to book appointments |  |
| I wish to have access to request repeat prescriptions |  |
| I wish to have access to the SCR (summary care record) |  |
| I wish to have access to full clinical record (please be aware access will be given from the date requested not historically) |  |

I wish to have proxy access to the stated patient’s medical record online and understand and agree with each statement (please tick all)

Proxy Signature …………………………………………

Relationship to Patient……………………………………………… …

Date:

Patient Signature …………………………………………

Date:

|  |  |
| --- | --- |
| 1. I will be responsible for the security of the information that I see or download |  |
| 2. If I choose to share my information with anyone else, this is at my own risk |  |
| 3. If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible |  |
| 4. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible |  |
| 5. If I think that I may come under pressure to give access to someone else unwillingly I will contact the practice as soon as possible. |  |

# For practice use only

|  |  |  |
| --- | --- | --- |
| ID seen: | Date account created: | |
| Identity verified by (initials): | Method: Vouching   Photo ID and proof of residence  | |
| Signature of staff member: | | Date: |