MEMORIAL MEDICAL CENTRE

Application for proxy access to online services

Patient details:			
Surname		**Forename**	
Date of birth		**NHS number**	
Street		**Region**	
Town or city		**Postcode**	
Telephone		**GP details**	
Nominated individual details:			
Surname		**Forename**	
Date of birth		**GP Practice**	
Street		**Town**	
Postcode		**Telephone**	
Email address		**Legal basis for access (Power of attorney)**	

I give permission for my nominated individual to have proxy access to the online services as detailed below:

Booking appointments	
Requesting repeat prescriptions	
Accessing my medical record	

I am aware that my GP may overrule my decision at any time and that this authorisation will remain in force until ...../...../..... or until cancelled by me (in writing). I understand the risks of allowing someone else access to the online services detailed above.

Signature (of patient)	
Date	

I agree that I will treat all information confidentially and will not disclose this information to any third party without the express permission of the person named as the patient above. I will only use this information in the best interests of the patient.

Signature (of nominated individual)	
Date	

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For practice use only

Patient NHS number		Practice computer ID number	
Identity verified by (initials)	Date	Method Vouching ☐ Vouching with information in record ☐ Photo ID and proof of residence ☐	
Authorised by			Date
Date account created			
Date passphrase sent			
Level of record access enabled All ☐ Prospective ☐ Retrospective ☐ Detailed coded record ☐ Limited parts ☐		Notes / explanation	