**GRENOSIDE SURGERY and WADSLEY BRIDGE MEDICAL CENTRE**

[www.grenosidesurgery.com](http://www.grenosidesurgery.com)

<https://patient.emisaccess.co.uk/>

**Consent to Proxy Access to GP Online Services (Adult)**

**If the patient does not have the capacity to consent to grant proxy access Section 1 of this form may be omitted but a GPs signature will be required in section 3.**

**Section 1**

**I** …………………………………………………………………………………………………………………………………………..……………. **(*name of patient*), give permission to my GP practice to give the following people**

…………………………………………………………………………………………………………………………………………………………...

**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 have read and understand the information leaflet provided by the practice.**

|  |  |
| --- | --- |
| **Signature of patient** | **Date** |

**Section 2**

|  |  |
| --- | --- |
| 1. **Online Appointments Booking**
 |  |
| 1. **Online Repeat Prescriptions**
 |  |
| 1. **Immunisations & Allergies**
 |  |
| 1. **Detailed Coded Records (Optional)**
 |  |

**Section 3: Complete if Patient is Unable to Grant Proxy Access Signature of GP if it is deemed that the patient does not have capacity to grant proxy access: Signature of GP Date GP NAME - PRINT**

|  |  |
| --- | --- |
| **GPs Name:** | **GP Signature:** |

**Section 4**

**I/we ……………………………………………………………………………………………………………………………………………….**

**Wish to have online access to the services ticked in the box above in Section 2 for: -**

**……………………………………………………………………………………………………………………………............................(*name of patient*). I/we understand and agree with each of the following statements:**

|  |  |
| --- | --- |
| 1. **I/we have read and understood the information leaflet provided by the practice and agree that I will treat the patient information as confidential**
 |  |
| 1. **I/we will be responsible for the security of the information that I/we see or download.**
 |  |
| 1. **I/we 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/we see information in the record that is not about the patient or is inaccurate, I/we will contact the practice, in writing, as soon as possible.**
 |  |
| **Signature/s of representatives:** | **Date/s** |
| **Signature/s of representatives:** | **Date/s** |

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

|  |  |
| --- | --- |
| **Surname** | **Date of birth** |
| **First Name**  |
| **Address****Postcode** | **GP Name** |
| **Email address** |
| **Telephone number** | **Mobile number** |

**The Representatives**

**(These are the people seeking proxy access to the patient’s online records, appointments or repeat prescription).**

|  |  |
| --- | --- |
| **Surname** | **Surname** |
| **First name** | **First name** |
| **Date of birth** | **Date of birth** |
| **Address****Postcode** | **Address (tick if both same address) □****Postcode** |
| **Email** | **Email** |
| **Telephone** | **Telephone** |
| **Mobile** | **Mobile**  |

**For practice use only**

|  |  |
| --- | --- |
| **The Patient’s NHS number** | **The Patient’s EMIS ID number** |
| **Identity verified by****(initials)** | **Date** | **Method verification:** Information on record **□**Photo Identification **□** Proof of Residence **□** |
| Date account created |
| Date passphrase sent |
| Level of record access enabledAppointments □ Prescriptions □ Detail Coded Record □  | Notes/comments on proxy access |
| Code 9RN added to records  **□** |