YORK ROAD GROUP PRACTICE

YORK ROAD ▪ ELLESMERE PORT ▪ CHESHIRE ▪ CH65 0DB
Telephone No: 0151 355 2112
Website: www.yorkroadgroupppractice.co.uk | Facebook: York Road Group Practice
Instagram: @yorkroadgroupppractice

Patient Online: Registration form for a proxy user (11 to 15 years) 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), given 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 understand the risks of allowing someone else to have access to my health records.

Including any sensitive data that the proxy may not be aware of, which I may have disclosed to the practice or other health care professionals.

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

In order to authorise this proxy account access, the practice will need to see photographic identification from the guardian, and the patients birth certificate or care plan.

Signature of patient		Date	

Section 2

1. Online appointments booking	□
2. Online prescription management	□
3. Would you like your representative to view your:	
Allergies	□
Laboratory Test Results	□

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Documents	□
Immunisations	□
Problems	□
Consultations	□
4. Would you like your representative to view your full medical history or from the date you signed up?	
Full medical History	□
Or	□
From Todays Date	

Section 3

I/We ……. (Name of representatives) wish to have online access to the services ticket in the box above in Section 2 for …… (Name of patient.)
I/We understand my/our responsibility for safeguarding sensitive medical information and 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	□
2. I/we will be responsible for the security of the information that I see or download	□
3. If I choose to share my information with anyone else, this is at my own risk	□
4. I/we will contact the practice as soon as possible if I/we suspect that my account has been accessed by someone without my agreement	□
5. If/we I see information in my record that it not about me, or is inaccurate I/we will log out immediately and contact the practice as soon as possible	□

Signature of representative/ s		Date	

Section 4

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

Surname			
First name			
Date of birth			
Address			
Postcode			
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			
First name			
Date of birth			
Address			
Postcode			
Email address			
Telephone number		Mobile number	
Relationship to patient			

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ID of parent/Guardian verified	Photo ID □ Proof of residence □	Name of verifier	Date
Birth certificate, court order or looked after child information.	Birth Certificate □ Court Order □ Looked after Child information □	Name of verifier	Date
Name of person who authorised			Date