Phoenix Health Group

Limited Proxy access for GP online services for children under the age of 16

What you will need,

- For the representative to provide ID to Reception (Drivers Licence, Passport…)
- For the representative to provide Proof of parental responsibility to Reception (Birth Certificate of the Patient)

Section 1 a, If the child is under 11,

I, ……(name of parent / guardian), request access to the following person ……

- I confirm I have parental responsibility for the child and **WILL** provide evidence of this.
- I understand that proxy access will automatically be turned off when my child reaches the age of 11 and I will have to re-apply, if access is still required.

Section 1 b, If the child is over 11 and under 16,

I, ……(name of patient), give permission to my GP practice to give the following person …… proxy access to the online services indicated below in section 2.

- I reserve the right to reverse any decision I make in granting proxy access at any time.

Note: the representative still needs to provide proof of parental responsibility.

Signature of Patient	Date

Section 2

Please tick all that apply

Booking Appointments	
Requesting repeat prescriptions	

Detail Coded Access

Please only use this service if you require access to the patients' coded medical records. Using this service will slow your application as a medical records check must be completed.

Detail Coded Access	

Section 3

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

1. I understand and agree that I will treat the patient information as confidential.	
2. I will be responsible for the security of the information that I see or download.	
3. I will contact the practice as soon as possible if I suspect that the account has been accessed by someone without my agreement.	
4. If I see information in the records 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(parent)	Date

Section 4

The patient

(This is the person whose records are being accessed)

Surname:	Date of birth:
First name:	NHS Number:
Address:	
Email address:	
Telephone number:	Mobile number:

The representative/parent

(This is the person seeking proxy access to the patient's online services.)

Surname:	Date of birth:
First name:	NHS Number:
Address:	
Email address:	
Telephone number:	Mobile number:
Relationship to Patient:	

For practice use only

Identity verification	**Photo ID of the Representative:** ☐ **Form of ID .....** **Proof of Parental Responsibility:** ☐ **Form of Proof .....** If this is not recorded, then access will not be given.	Name of ID verifier	Date
Approved by Name Date			