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Consent to proxy access.

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 – Patient declaration

Name of patient:		Date of birth:	
NHS NUMBER			

- I give permission to Pathfields Medical Group to give the person/people indicated below proxy access to medical records.
- I understand that I may 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 this information.

Signature of patient:		Date:	

Section 2 – Consent options

Give consent for appointments to be arranged on my behalf.	
Give consent to discuss medical history	
Give consent to discuss prescription requests and queries	
Give consent for communication via SMS messaging and email.	
Give consent to access the following via online access:	
• Appointment booking	
• Request medication	
• Questionnaires	
• Summary record access	
• Detailed coded record access (this includes a brief version of full online access with test results and historic diagnoses).	
• Full clinical record access (this includes test results, consultation details and documents in your record).	

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Section 3 – 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		Address	
Postcode		Postcode	
Email		Email	
Telephone		Telephone	
Mobile		Mobile	
Relationship to Patient		Relationship to patient	

Section 4 –The patient (If the patient does not have capacity)

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

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Section 5 – Representative Declaration

I/We …… (names of representatives) wish to have access to the information ticked in the box above in Section 2 for …… (name of patient)

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

I/We will be responsible for the security of the information that I/we see	
I/We will contact the practice as soon as possible if I/we suspect that the information has been accessed by someone without my/our agreement.	

Signature(s) of representative(s):		Date(s):	
Signature(s) of representative(s):		Date(s):	