Proxy Access Application Form

|  |  |
| --- | --- |
| Details of Patient | Date of birth |
| Name | |
| Address  Postcode Signed: | |
| Email address | |
| Telephone number | Mobile number |

I wish to give proxy access for the following online services (please tick all that apply):

|  |  |  |
| --- | --- | --- |
| 1. Booking appointments | |  |
| 2. Requesting repeat prescriptions | |  |
| 3. Accessing my medical record | |  |
| PROXY: | |  |
| Name | | | |
| Address Date of Birth:  Postcode Relationship to Patient: | | | |
| Email address | | | |
| Telephone number | Mobile number | | |

I am a patient of The Cedars Surgery Yes/No

Date

Signature

**For practice use only**

|  |  |  |  |
| --- | --- | --- | --- |
| Patient NHS number | | Practice computer ID number | |
| Identity verified by (initials) | Date | Method Citizen Identity  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 | |