**Stokewood Surgery**

[**www.stokewood.co.uk**](http://www.stokewood.co.uk)

**PROXY Online access for children aged 11 years until their 16th birthday**

Patient’s Full Name: ………………………………………………………………………

Patient’s Date of Birth: ……………………………………………………………………

Patient’s Address: …………………………………………………………………………

**Information regarding access to online services:**

You have decided to grant a family member or carer access to your medical records online account. The person you are granting access to will be able to do the following things on your medical record:

**Tick the service you are granting access to**

Request medication

Book Appointments

Access medical records including vaccinations, results & clinical letters.

**Stopping access:**

Proxy access to your online account will be stopped on the day of your 16th birthday.

Even though you have granted access today, you can **STOP** the access at any time by letting us know in writing, in person or email, that you no longer want the above person to have access to your records.

**Please sign below to confirm that you have read and understood the information on this form.**

Signature:…………………………………………… Date: …………………………

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**Details of the Parent/Guardian requesting PROXY access:**

Full Name: ………………………………………………………………………………..

Date of Birth: ……………………………………………………………………………..

Address: ………………………………………………………………………………….

Relationship: …………………………………………………………………………….

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please sign to confirm that you have read and understood the information on this form.**

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

|  |  |
| --- | --- |
| I will be responsible for the security of the information that I/we see or download | 🞏 |
| I will contact the practice as soon as possible if I suspect that the account has been accessed by someone without my/our agreement | 🞏 |
| If I see information in the record 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:………………………………………………… Date: …………………………….

**Both Child & Parent/Guardian must be seen in person & both must have a form of ID on them**

**Child: Birth certificate or passport**

**Parent Guardian: proof of address and photo ID such as driving licence or passport**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Stokewood Staff to complete**

**STAFF: to check with the child that they are competent enough to decide that they can:**

1. Stop their parents’ proxy access to their online services, where the parents still have access after the 11th birthday

2. Allow their parents to have access to their online services, or to allow limited proxy access to specific services, such as appointment booking or repeat prescription requests, but not to the medical records

3. Switch off all online access until such time as the young person chooses to request

access.

Tick to say you have seen and spoken to child about granting proxy access

*Childs ID Documentation seen: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Parent / Guardian ID Documentation seen:-----------------------------------------------------*

*Date seen \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_*

*Staff Members Initials \_\_\_\_\_\_\_\_\_\_*