**Proxy Access Child 13 – 15**

**Child Details:**

|  |  |
| --- | --- |
| First name : |  |
| Surname : |  |
| Date of birth: |  |
| Address: |  |
| Email address: |  |
| Tel number: |  | Mob number: |  |

|  |
| --- |
| Signature of patient: |

**Proxy Details:**

|  |  |
| --- | --- |
| First name : |  |
| Surname : |  |
| Date of birth: |  |
| Address:*(If different to above)* |  |

**Section 1** I,………………………………………………….. (Name of patient), give permission for my GP practice to give the following people ….………………………………………………………………..…………….. proxy access to the online services as indicated below. 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.

|  |  |  |
| --- | --- | --- |
|  | **REQUEST TO ACCESS** | **ACCESS GRANTED** |
| Book Appointments |  |  |
| Cancel Appointments |  |  |
| Request Repeat Medication |  |  |
| **Church Lane Medical Centre also offer ‘summary.’ ‘coded’ and ‘full’ record access. If you would like more information about this please ask at reception** |

**For Practice Use Only:**

|  |  |  |
| --- | --- | --- |
| Identity verified by | Date: | Method: |
| Date Access Granted: |  | Level of access granted: |