Castle Medical Group

Agreement to Proxy (Parental) access to GP online services for Children aged 11-12 years old

Section 1

I…… have no objections to my GP practice allowing the following people

(insert name/s)……..……..
having parental access to the online services as indicated below in section 2.

I reserve the right to deny parental access at any time subject to a competence assessment with a Doctor.

I understand the risks of allowing someone else to have rights to my online access.

I understand that proxy access will be removed when I reach my 13th birthday or if I decide to withdraw consent, whichever is sooner.

Signature of patient	Date
I understand that I am allowing parental access. If I want to change my mind, I will contact the Practice to arrange a competence assessment with a Doctor. I also understand that this agreement will remain in place until my 13th Birthday at which point I will need to reapply for access.	

Section 2 (please tick services required)

1. Online appointments booking	☐
2. Online prescription management	☐

Section 3

I/we…….. (names of parents/guardians) wish to have online access to the services ticked in the box above in section 2

for …… (name of patient).

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

1. I/we have read and understood the information leaflet provided by the practice and agree that I will treat the patient information as confidential	☐
2. I/we will be responsible for the security of the information that I/we see or download	☐
3. I/we will contact the practice as soon as possible if I/we suspect that the account has been accessed by someone without my/our agreement	☐

Signature/s of parents/guardians	Date/s

Section 4

The patient

(This is the person whose records are being accessed)

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

The representatives

(These are the people seeking parental access to the patient's appointments or repeat prescription.)

Surname	Surname
First name	First name
Date of birth	Date of birth
Address Postcode	Address (tick if both same address ☐) Postcode
Email	Email
Telephone	Telephone
Mobile	Mobile

For practice use only

Date of ringback with usual GP		
Identity verified by (initials)	Date	Method of verification *(please tick one)* Vouching ☐ Passport/Birth Certificate ☐ Other ☐ Please Specify……