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Castle Medical Group

Agreement to Proxy (Parental) access to GP online services for Children aged 11-15 years old

Section 1

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

(insert name/s).....
having parental access to the following online services (**please tick all that apply**):

1	Online appointments booking	☐
2	Online prescription management	☐

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 16th birthday, where I will need to re-apply for access in my own right, or if I decide to withdraw consent, whichever is sooner.

Signature of patient:	Date:

Section 2

I/we..... (names of parents/guardians) wish to have online access to the services ticked in the box above **in section 1** 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	☐
4	I/we understand that proxy access will be granted for one year from the date of approval and it is my/our responsibility to re-apply for access.	

Signature/s of parents/guardians:	Date/s:

Section 3

The patient

(This is the person whose records are being accessed)

Surname	First Name(s)
Date of birth	
Address Postcode	
Email address (by giving an email address you are consenting to be contacted in this manner)	
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 office use only

ID provided:		Staff initials:	