Proxy Access Application Form

|  |  |
| --- | --- |
|  Details of Patient | Date of birth |
| Name |
| AddressPostcode 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 IdentityVouching Vouching with information in record Photo ID and proof of residence  |
| Authorised by | Date |
| Date account created |
| Date passphrase sent |
| Level of record access enabledAll  Prospective  Retrospective  Detailed coded recordLimited parts  | Notes / explanation |