River Wey Medical Practice

Application for Proxy User Access
Children Only up to the age of 11.

Patient for which access is being requested					
Title		First Name		Last name	
Gender	Male/Female			Date of Birth	
Address					

***If the patient does not have capacity to consent this should be signed by the person holding lasting power of attorney for health and welfare or by the GP.**

Proxy Users applying for access to the above mentioned child					
Title		First Name		Last name	
Gender	Male/Female			Date of Birth	
Address					
Email					
Relationship to Patient					
Title		First Name		Last name	
Gender	Male/Female			Date of Birth	
Address					
Email					
Relationship to Patient					

TO BE COMPLETED BY THE PROXY USER/USERS APPLYING FOR ACCESS			
I/we understand my/our responsibility for safeguarding sensitive medical information and understand and agree with the following statements *(please tick to indicate agreement):*			
I/we will be responsible for the security of the information that I/we see or download.			
I/we will contact the practice as soon as possible if I/we suspect that the account has been accessed by someone without the patient's agreement.			
If I/we see information in the record that is not about the patient or is inaccurate, I/we will contact the practice as soon as possible, I/we will treat any information which is not about the patient as being strictly confidential.			
Signature		**Date**	
TO BE REVIEWED BY THE GP			