**BOX SURGERY PROXY ACCESS FOR ADULTS**

**If the patient has full capacity, we require written consent that is signed by the patient and attached to the application form specifying the access they wish to allow.**

**If the representative has Power of Attorney for Health & Welfare, please provide the surgery with a copy to add to the patient’s record.**

**Patient Details:**

|  |  |
| --- | --- |
| **Surname** |  |
| **First Name**  |  |
| **Address****(Including postcode)** |  |
| **Date of Birth**  |  |
| **Preferred telephone number** |  |
| **Email address**  |  |

**I agree with the following (please tick):**

|  |  |
| --- | --- |
| I have read and understood the information leaflet |  |
| I will be responsible for the security of the information that I see or download |  |
| I will treat the patient information as confidential  |  |
| If I see information in the record which is not about the patient or is inaccurate, I will contact the practice as soon as possible. I will treat any information which is not about the patient as confidential  |  |
| I understand access will be available within the next 21 days |  |

**Representative Details:**

|  |  |
| --- | --- |
| **Surname** |  |
| **First Name**  |  |
| **Address****(Including postcode)** |  |
| **Date of Birth**  |  |
| **Preferred telephone number** |  |
| **Email address**  |  |

I give permission for the practice to contact me via text message

I give permission for the practice to contact me via email

|  |  |
| --- | --- |
| **Signed** |  |
| **Date**  |  |

**I wish to have access to the following (please tick)**

|  |  |
| --- | --- |
| **Booking and cancelling appointments**  |  |
| **Requesting repeat prescriptions** |  |
| **Limited access to medical record**  |  |

**Reason for proxy access (please tick):**

|  |  |
| --- | --- |
| **Patient** |  |
| **Patient lacks capacity – court order** |  |
| **Patient lacks capacity – Power of Attorney** |  |
| **Patient lacks capacity – patient’s best interests** |  |

**For surgery use**

**If the patient has full capacity, we require written consent that is signed by the patient and attached to the application form specifying the access they wish to allow.**

**If we do not have written consent from the patient, task the named GP.**

Reception:

|  |  |
| --- | --- |
| **Type of ID (please tick)***Take a copy of the ID and scan with the form into the patient record* | PassportDriving LicenceOther, please specify  |
| **Representative (please tick)** | Documentation seenVouched for  |
| **ID verified by (receptionist name)** |  |

Admin

|  |  |
| --- | --- |
| **Access enabled on TPP (please tick)** |  |
| **Initials**  |  |
| **Date**  |  |

Scan this form to the patient record once completed.