**BOX SURGERY PROXY ACCESS FOR CHILDREN (AGE 0-16 YEARS)**

**Age 0-10 years:** Parents can apply for access to their child’s record. When child reaches 11 years old, Box Surgery will switch off proxy access. Parents can have access to prescription ordering, appointment booking and detailed coded access.

**Age 11-16 years:** Each application is considered individually with the interests of the child being paramount as children in this age range can be considered to be competent to make their own decisions about their healthcare.

**Age 16+ years:** Proxy access is turned off on the patient’s 16th birthday. It is encouraged that the patient has their own log in details from this age. We understand this may not be appropriate in specific cases.

**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** |  |
| **Parental responsibility**  |  |
| **Patient lacks capacity – court order** |  |

**For surgery use**

**0-10 years old: parents’ photo identification [take a photocopy]**

**11-15 years old: child’s (patient) photo identification e.g. birth cert, passport, other form of photo ID [take a photocopy]**

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  |
| **If parental responsibility (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 (child) record once completed.