|  |  |
| --- | --- |
| PATIENT Details  | PROXY Details |
| Name: | **Name:** |
| Address: | **Address:** |
| Post Code: | **Post Code:** |
| Telephone: | **Telephone:** |
| Email: | **Email (Mandatory):** |
| Mobile: | **Mobile:** |
| Date of Birth: | **Date of Birth:**  |
|  | **Relationship to patient:** |

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ give permission the above named to have access to my medical records and personal details held by the Practice via the Online Services – Patient Access / NHS App.

This permission relates to **all / part** of my records. ((**Delete as appropriate**))

I give permission for the following;

Requesting repeat prescriptions [ ]

Access to parts of my medical record currently available [ ]

* I understand that this consent will remain in force indefinitely. However, my doctor may, at my request, override this authority to allow access to my medical records via the Patient Access/Online Services at any time.
* I reserve the right to reverse any decision I make in granting proxy access at any time.
* I understand the risks of allowing someone else to have access to my medical records.

**Signed**.............................................................................. (**Patient**)

Date..................................................................................

* I will treat any information provided confidentially.
* I will not disclose information to a third party without agreement.
* I will only use the information in the person that I have proxy access for in their best interest.

**Signed**................................................................................ (**Proxy)**

Date...................................................................................