**Patient online record viewing application form for Children Under the Age of 16 years old**

PLEASE ENSURE YOU HAVE A FORM OF FORMAL PHOTO ID WHEN HANDING IN THIS FORM AS WE CANNOT GRANT ACCESS WITHOUT VERIFYING YOUR IDENTIFICATION.

Parents can be given proxy access only for: Appointments · Medication · Immunisation

**This form needs to be completed if you would like Proxy Access for your child – linked to your account**

|  |  |
| --- | --- |
| Name of child: | Your name: Your Date of Birth: |
| Date of birth: | Relationship to patient: |
|  |   |
| Address    |   |
| Postcode  |   |
| Email address  |   |
| Telephone number  |   | Mobile number  |   |

*I wish to have access to the following online services (tick all that apply):*

|  |  |
| --- | --- |
| Booking appointments  |  |
| Requesting repeat prescriptions  |  |
| Immunisations |   |

**Application for online access to a child’s medical record**

*I wish to access my medical record online and understand and agree with each statement (please tick)*

|  |  |
| --- | --- |
| I understand this proxy access is going to switched off at the age of 16 |  |
| I will be responsible for the security of the information that I see  |  |
| If I choose to share the information with anyone else, this is at my own risk  |  |
| I will contact the practice as soon as possible if I suspect that my account has beencompromised |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Signature  |    | Date  |   |

**Office use only**:

Identification documents seen. Name: Signature:

 PIN document if required Patient check Details checked/updated Settings checked/updated Patient coded