Representative Person Consent Form

This form must be completed and signed by the patient. The patient is the person whose records are being accessed.

Once this form has been completed and returned to us, we will need to complete our verification process before authorisation.

If the patient has a 'Lack of Mental Capacity' and is unable to consent to this request, we require a copy of the 'Health and Welfare Lasting Power of Attorney' evidencing your entitlement to this information.

Part 1 – Patient and Representative Details

Patient details:

Patient Surname:	Patient NHS Number:
Patient Forename (s):	Patient Date of Birth:
Patient Full Address (including postcode):	

Please print details of the representative person (the person requesting access to patient record):

Surname:	Date of Birth:
Forename (s):	Telephone number: Mobile number:
Email Address:	
Full Address (including postcode):	
Relationship to Patient:	

- If you are requesting **online proxy access**, please complete part 2
- If you are requesting **permission to discuss** medical records with the practice staff, please complete part 3
- If you are requesting **both** of the above, please complete both parts 2 and 3.

Part 2 – Online Proxy Access

Online proxy access enables the representative person to view specified parts of the patient's medical records through digital platforms such as the NHS app or website.

Please tick the statement/s applicable:
I hereby give consent for the representative person to have online proxy access to the following:

Test Results	
Manage and view appointments	
Problems list	
Documents	
Prescriptions	
Consultation notes	
Immunisations	
All of the above	

Part 3 - Permission to discuss medical records with the practice staff

Please tick the statement/s applicable:
I hereby give consent for Moatfield Surgery to discuss the following information with the above representative person:

Full and open disclosure of any medical matter related to my medical record	
Limited disclosure of the following aspects of my medical record:	
Test Results	
Prescriptions	
Appointments	
Documents	
Consultation notes	
Problems list	
Immunisations	
Referrals	
Other, please state:	

Part 4

Note: If the patient has a 'Lack of Mental Capacity' and is unable to consent to this request, we require a copy of the 'Health and Welfare Lasting Power of Attorney' evidencing your entitlement to this information.

Patient Declaration

I,…….. (name of patient), give permission to my

GP practice to give the following person……access to, and

the ability to discuss, my medical records as indicated in **Parts 2 and 3.**

- I reserve the right to reverse any decision I make in granting access at any time.
- I understand the risks of allowing someone else to have access to my health records.
- I have read and understand the information leaflet provided by the practice

Signature of patient …… Date ……

Representative Person Declaration

I, …….. (name of representative person) understand my responsibility for safeguarding sensitive medical information and by signing below I am confirming that I understand and agree with the following statements

1. I understand that I can request information and educational resources from my GP Practice
2. I will be responsible for the security of the information that I see or download
3. I will contact the practice as soon as possible if I suspect that the account has been accessed by someone without my agreement
4. If I see information in the record that 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 being strictly confidential
5. If I think that I may come under pressure to give access to someone else unwillingly I will contact the practice as soon as possible

Signature of representative person ……..

Date ……

Part 5 – FOR PRACTICE USE

Identity verified by:	Date:	Method:
		Photo ID ☐ Information confirmation vouching ☐ Personal vouching ☐
Evidence provided (if information confirmation, state the questions asked and answers given)		

If enhanced review required, please complete below

Reviewed and authorised by:	Date: