# Proxy Application for online access (Over 16)

| | | |
|---|---|---|
| Name of Person for whom Proxy Access is being sought | | |
| SURNAME | | D.O.B |
| FIRST NAME | | |
| ADDRESS | | |
| EMAIL ADDRESS | | |
| TELEPHONE NUMBER | MOBILE NUMBER | |
| I/We wish to have proxy access to the following online services (please tick all that apply) | | |
| 1. Booking appointments | | |
| 2. Requesting repeat prescriptions | | |
| 3. Receive Text Messages | | |
| I/we wish to have access to book appointments and request repeat prescriptions. I/we will contact the practice as soon as possible if I/we suspect this proxy account has been accessed by someone else without my /our agreement. I/we know we can see the Trinity Medical Centre Privacy Notice on the website or in the waiting room. | | |
| I/we are the parent/guardian/carer of the person named above | | |
| Signature of parent/guardian (if joint parental responsibility then both parents are requested to give signed consent)<br>Name: Signature: | | Date |
| ADDRESS | | |
| EMAIL ADDRESS | | |
| TELEPHONE NUMBER | MOBILE NUMBER | |
| I/we give consent for the document to register for online services to be sent to the first parent's e-mail address shown on this form | Signature and date | |
| Signature of parent/guardian/Carer (if joint parental responsibility then both parents are requested to give signed consent)<br>Name: Signature: | | Date |
| ADDRESS | | |
| EMAIL ADDRESS | | |
| TELEPHONE NUMBER | MOBILE NUMBER | |
| I give consent for the document to register for online services to be sent to the first parent's e-mail address shown on this form. | Signature and date | |
| For office use only | Staff member to complete below | |
| Proof of ID given | Yes(please specify | |
| Identity Confirmed | Yes (please initial) | |
| On line registration documents printed/emailed and e-mail verified in patient's record | Print name and sign | |