THIS FORM MUST BE FILLED OUT AND SIGNED BY HAND AND BROUGHT TO THE SURGERY IN PERSON WITH PHOTO ID AND PROOF OF ADDRESS

Application for 3rd party proxy access for online services

Patient Details who are registered at Hawthorn Medical Centre	
Surname	Date of birth
First name	
Address Postcode	
Email address	
Telephone number	Mobile number
Patient Signature	**Date:**
3rd Party Proxy Access Details (not registered at Hawthorn Medical Centre)	
Relationship to Patient	
Surname	Date of birth
First name	
Address Postcode	
Email address	
Telephone number	Mobile number
3rd Party Signature	**Date:**

I wish to grant the above named person 3rd party proxy access to the following online services (please tick all that apply):

• Booking appointments	☐
• Requesting repeat prescriptions	☐

For practice use only (Reception to complete the grey section)

3rd Party Identity verified by (initials)	Date	Method Vouching ☐ Photo ID and proof of residence ☐ Type of ID: _____
Authorised by (Admin)		Date (Admin)
Date account created (Admin)		
Date passphrase sent (Admin)		