***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<br><br>Postcode | |
| Email address | |
| Telephone number | Mobile number |
| **Patient Signature** | **Date:** |
| **3rd Party Proxy Access Details (who is registered at Hawthorn Medical Centre)** | |
| Relationship to Patient | |
| Surname | Date of birth |
| First name | |
| Address<br><br>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<br>Vouching ☐<br>Photo ID and proof of residence ☐<br>Type of ID: ______________________ |
|---|---|---|
| Authorised by (Admin) | | Date (Admin) |
| Date account created (Admin) | | |
| Date passphrase sent (Admin) | | |