**PROXY ACCESS - ONLINE SERVICES ACCESS (16-17 years)**

|  |  |
| --- | --- |
| **PATIENT** | |
| Name: | D.O.B: |
| Address: | |
| Contact Numbers: | |
| Reason for Proxy Access: | |
| By signing this document you are permitting the below person to have full access to your online services which may contain sensitive private information. | |
| Signature of Patient: | Date: |

|  |  |
| --- | --- |
| **PROXY ACCESS** | |
| Name: | D.O.B: |
| Relationship to patient: | |

|  |
| --- |
| **FOR RECEPTION USE ONLY**  I have seen patients ID (please not type of ID presented): **Y**  Name of Employee: Date:  Signature of Employee: |