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

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| **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: |

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

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