Repeat Delivery & Electronic Prescription Patient Consent Form

Patient Details	
Name:	**Date of Birth:**
Address:	
Phone:	**Do you pay for your Medication?**
Please give the name of the pharmacy (chemist) where you normally have your prescriptions dispensed.	
Pharmacy Name:	

I am the above named patient or the patient's representative. I understand the Repeat Delivery method as well as the NHS Electronic Prescription Service with Pharmacy Nomination procedure (futher information is available at www.hscic.gov.uk/epspatients). I wish to nominate iPharm Pharmacy to supply my medication by the Repeat Delivery method, to receive my prescriptions electronically, and for information on my medication or treatments to be exhanged between my GP and the Pharmacist. I also authorise iPharm Pharmacy to sign the back of my prescription as my representative and will notify them of any changes with respect to my payment/ exemption status. I understand that I can cancel or change my nomination at any time.

Patient's Signature _____ Date _____

Doctors Details
GP Name:
GP Address:
GP Phone:

New Pharmacy Details			
Pharmacy Name:	iPharm UK		
Pharmacy Address:	Unit 4A, 11 Jameson Road, Aston, Birmingham B6 7SJ		
Pharmacy Phone:	0121 366 8790	**Pharmacy Fax:**	0121 328 7134

All copies to be retained by the GP Practice and the Pharmacy. All data will be handled confidentially.
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Once completed, please send a copy of this form to iPharm. You can send it to us by fax, e-mail, or through the post.

0121 328 7134

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enquiries@ipharm-uk.com