

Permission to allow <Insert care home name> to order my repeat medication using GP online services proxy access

Resident's name		Resident's date of birth	
Resident's address	<Insert care home address>	Postcode	<Insert care home postcode>
Resident's phone number			
Resident's email address			

Tick one of the options below

I am the resident	☐
I am the resident's next of kin or person with legal power of attorney and agree to the online ordering of repeat medication by the care home, in the best interests of the resident.	☐
I am the manager of the resident's care home and agree to the online ordering of repeat medication by staff in the absence of next of kin, believing this to be in the best interests of the resident.	☐

Please read the following and tick each statement you agree with

I reserve the right to change my mind at any time	☐		
I understand the risks of allowing someone else to have access to my health record	☐		
I have read and understand the information leaflet provided by the care home	☐		
Signature		Date	

For the care home

I confirm I have verified the identity of this resident in accordance with our organisation's ID verification protocol			
Signature		Date	