MEDICATION COLLECTION

Authorised Collection Consent Form

If you are happy for other people to collect medication on your behalf please complete this form and return it to the Surgery.

Please note that the person collecting medication may, on occasion be asked to pass on a message from the Dispensary or Doctor regarding your medication.

By completing this form you are agreeing that you are happy for the people listed below to take such messages on your behalf. We will not discuss your medical care with the person collecting your medication unless you have previously authorised us to do so by informing us that they are your nominated carer / representative.

If you have an exemption from Prescription charges, it is your responsibility to ensure the person collecting your medication has full details of your exemption and any other information needed to correctly complete the reverse of the form.

Your Full Name: _____

Your Date of Birth: _____

Your Address: _____

_____

_____

_____

Your Contact N^{o}: _____

I, give permission for the following people to collect medication on my behalf:

Representatives names:

1. _____
2. _____
3. _____
4. _____

Your Signature _____ Date _____