Prescription Service Consent Form

Please fill out the details below, giving your consent for Midlands Pharmacy to order, collect and deliver your repeat/non-repeat prescriptions.

Title: ..... Forename: ..... Surname: ..... DOB: .....

Address: .....

.....

Post Code: .....

Home Telephone: ..... Mobile: .....

Email: .....

Doctors Name: .....

Surgery Name: .....

Surgery Address: .....

Surgery Telephone: .....

I wish to nominate Midlands Pharmacy to order, collect and deliver my prescriptions from my medical practice.

I agree that Midlands Pharmacy will make arrangements for all my future prescriptions to be dispensed in this way including Electronic Repeat Dispensing. If I wish to change this arrangement I will inform Midlands Pharmacy.

I consent to Midlands Pharmacy holding my personal information provided on this form.

I agree to the exchange of information about my medication or treatment between my GP Practice and Midlands Pharmacy as part of the prescription dispensing arrangements.

I agree for my information to be used anonymously for the purpose for auditing and medical research purposes.

Signature: .....

Date: .....

Please complete the form and return to: **Midlands Pharmacy, Office 4, Southwold Drive, Nottingham NG8 1PA**