# TMC standard header jpg 1.jpg

# Consent form for prescription collection & authorisation to discuss medical records with a third party

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By completing this form I give permission for …………………………………………………………….. to:

**(Please tick the relevant boxes)**

* Collect my prescriptions on my behalf
* Discuss my medical care and records
* Be recorded on my records as my next of kin

*(If you tick box 3 for next of kin please add contact number: ……………………………………………)*

**Please bring Photo ID\* with this slip into the surgery to allow the staff to update your records for future reference**

**\*Photo identification may include Passport or drivers license.**

Signed: .………………………………………………………. Date ……...……………………………………..