TRINITY MEDICAL CENTRE
1 Goldstone Villas
Hove
BN3 3AT

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:

Relationship to patient:……..

(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 this slip into the surgery to allow the staff to update your records for future reference

Signed: ……. Date ……..