**Harbury Surgery**

**PATIENT THIRD-PARTY CONSENT**

|  |  |  |
| --- | --- | --- |
| **Patients Name:** |  | |
| **Patients Telephone Number:** |  | |
| **Patients Address:** |  | |
| **Date of Birth:** |  | |
| I fully consent to my Harbury Surgery to hand out my prescription or prescription items to the person/persons named below. (Please list everyone’s name you think who will collect your script).  This authority is for an indefinite period [ ] or for a limited period only [ ] *(tick one).*  Where a limited period applies, this authority is valid until …………………... *(insert date).* | | |
| Third Party details  Name: Address Telephone No.  \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_  \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_  \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_  \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ | | |
| Signed:  (Patient only) | | Date: |

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| --- | --- |
| **Dispensary Staff Use Only** | |
| Added to Patient Home Screen: |  |
| Staff Initials: |  |
| Date Actioned: |  |
| **PLEASE NOW SCAN & COMPLETE** | |