**Harbury Surgery**

**PATIENT THIRD-PARTY CONSENT**

|  |  |
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| **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 detailsName: 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** |