Leybourne
PHARMACY

Patient Name		D.O.B	
Address			
Contact Details			
Surgery name and address			

I give consent for Leybourne Pharmacy to:
(please tick each option as applicable)

Activity	*Please tick to consent*
Order my repeat prescription from the surgery stated above	
Take my completed repeat prescription request slip to the surgery stated above	
Collect my prescription from the surgery stated above	
Deliver my medication to the address stated above	
Deliver my medication to an alternative address [state address below]:	
Access my Summary Care Record - on this occassion only	
Access my Summary Care Record - whenever I need care at this pharmacy [reviewed annually]	

Notes	● Medication will only be delivered to the address stated on this form ● All medication will need to be signed for upon delivery ● Any undelivered medication will be returned to the pharmacy ● Medication will not be posted through letterboxes or left in a 'safe place'
Consent	● Any confidential information supplied will be processed and used for the purposes above. This may also include: ○ Sharing information with your GP practice ○ Storing for record keeping purposes ● I understand that I can change or amend this consent at any time and will inform Leybourne Pharmacy at the earliest opportunity

Patient Signature		Date	

Pharmacy Details	
Pharmacy Name	
Pharmacy Address	