Repeat My Medicine Form

PHAKEYS

Pharmacy

First Name: .... Surname: ....

Address: ....

....

Post Code: .... Date of Birth: ....

Telephone: .... Mobile: ....

Email Address: ....

Doctor's Name: ....

Surgery Address: ....

....

Surgery Telephone Number: ....

I give my consent for my local Phakeys Pharmacy to retain my repeat slip, order my repeat prescription and collect from my GP surgery (either in person or by electronic transfer).

I agree to Phakeys Pharmacy contacting myself or my GP's surgery to verify my required prescription items, or to advise me my repeat prescription is ready for collection.

I give my permission for Phakeys Pharmacy to hold the information provided on this form.

I give my consent for this information to be used in an anonymised format for statistical and medical research purposes.

Phakeys Pharmacy may contact you regarding healthcare services offered in store.
Please tick the box if you do not wish to be contacted. ☐

I will contact Phakeys Pharmacy direct should I wish to change this agreement.

Please return your completed form to:

Phakeys Pharmacy
149 Carlton Road,
Nottingham,
NG3 2FN

Signed..

Date...