Howard Medical Practice

**Consent for Medical Prescriptions to be Collected by Other Individuals**

|  |  |  |
| --- | --- | --- |
| **Patient Name** |  | |
| **D.O.B** |  | |
| **Post Code** |  | |
| **Signature** |  | |
| I hereby give my consent for the following individual/s to collect prescriptions on my behalf: | | |
| **Name** | |  |
| **D.O.B** | |  |
| **Signature of nominated individual** | |  |
| **Name** | |  |
| **D.O.B** | |  |
| **Signature of nominated individual** | |  |

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