

## Consent Form

Name: ..... Date of Birth: .....

Address: .....

Mobile number: ..... Email address: .....

*Please tick the sections you are consenting to and return this form to reception:*

I consent to collecting my prescriptions at Garswood Pharmacy:

I intend to have my prescriptions dispensed by Garswood Pharmacy:

I consent to the practice contacting me by text message and have provided by mobile number above. I understand that no personal information to identify me will be sent by text message and that I can cancel the text message facility at any time.

I consent to the practice contacting by email and have provided my email address above:

Patient signature: ..... Date: .....

*We adhere to the NHS code of practice for information security management.  
A link to this can be found on our website: [www.garswoodsurgery.co.uk](http://www.garswoodsurgery.co.uk)*

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