RoskellsPharmacy

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 Roskells 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 Roskells 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 Roskells Pharmacy to hold the information provided on this form.

Roskells Pharmacy may contact you regarding healthcare services offered in store.
Please tick this box if you do not want to be contacted. ☐

I will contact Roskells Pharmacy directly should I wish to change this agreement.

Signed.....

Date.....

Roskells Pharmacy
175 Allesley Old Road
Chapelfield
Coventry
CV5 8FJ
Tel: 02476 672535
Fax: 02476 714935