

# Prescription Collection Registration Form

Title Mr / Mrs / Miss / Other .....

First name .....

Surname .....

Address .....

.....

Postcode .....

E-mail .....

Telephone .....

Date of birth .....

Your doctor's name .....

Surgery .....

I hereby authorise Wombourne Pharmacy to collect my prescription from the surgery on my behalf.

I will inform you if I wish to change this agreement.

Signed ..... Date .....

Data Protection: Wombourne Pharmacy will keep your details confidential.

**Please, either hand this form to pharmacy staff, post or fax  
back.**

Address: Wombourne Pharmacy, 45a Planks Lane, Wombourne, WV5 8DX

Tel/fax: 01902 893366