

*Please repeat  
my medicines...*



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 Numark 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 my local Numark pharmacy or Numark Limited 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 my local Numark pharmacy and Numark Limited 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.

Numark may contact you regarding healthcare services offered by your local Numark pharmacy. Please tick this box if you do not wish to be contacted.

I will contact my local Numark pharmacy if I wish to change this agreement.

Signed.....

Date.....