Inspire pharmacy
Prescriptions at a click

Repeat my medicine form

First Name: ..... Surname: .....

Address: .....

.....

Postcode: ..... Date of Birth: .....

Telephone: ..... Mobile: .....

Email Address: .....

Doctor's Name: .....

Surgery Address: .....

.....

Surgery Telephone Number: .....

I give my consent for my local Inspire 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 Inspire Pharmacy's 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 Inspire Pharmacy 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.

Inspire Pharmacy may contact you regarding healthcare services offered in store.
Please tick the box if you do not wish to be contacted. ☐

I will contact Inspire Pharmacy direct should I wish to change this agreement.

Signed: .....

Date: .....

Please complete and return your form to: