



Prescription Collection Registration Form

Patients Name.

Address.....

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Postcode..... Telephone number.....

Surgery Address.....

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Postcode.Telephone Number.....

Doctors Name.....

I hereby authorise Cox and Robinson Pharmacy to Collect, either in person or by means of electronic transfer my prescriptions.

Should I wish to change this agreement I will contact you.

Signed.....

Date.....

We also accept this form as registration for those patients who are housebound and require home delivery services