MALAHIDE FAMILY PRACTICE

Dr. Joanne Daly - Dr. Noelle Hewetson - Dr. Claire Fitzsimmons

Third-Party or Pharmacy Prescription Collection Cancellation Form

This form confirms that I wish to revoke any consent I have previously given to a nominated pharmacy or any other nominated third-party to collect my prescription or other requested medical information on my behalf. From this point onwards I wish to be solely responsible for the collection of my own prescription and requested medical information.

Patient Name: .....

Patient Date of Birth: ...../...../.....

Previously Nominated Third-Party(s):

1. .....

2. .....

3. .....

I hereby revoke any consent previously given to a pharmacy or nominated third-party to collect my prescription or other requested medical information. I understand that I will now have to personally collect from Malahide Family Practice any prescriptions or other medical information that I have requested, and I accept that Malahide Family Practice will not release any of my medical information to anyone other than myself unless a new Third-Party Collection Consent form has been signed and submitted.

Patient Signature: .....

Date Signed: ...../...../.....

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