Pharmacy Name
Address 1
Address 2
Address 3
Postcode

Consent to participate in the:

NHS New Medicine Service / NHS Medicines Use Review Service*

*delete as applicable

Patient name	
Address	

I agree that the information obtained during the service can be shared with:

- my doctor (GP) to help them provide care to me
- the Primary Care Trust (PCT – the local health authority) or successor organisation to allow them to make sure the service is being provided properly by the pharmacy
- the Primary Care Trust (PCT) or successor organisation, the NHS Business Services Authority (NHSBSA) and the Secretary of State for Health to make sure the pharmacy is being correctly paid by the NHS for the service they give me.

Signature	
Date	