



Repeat Prescription Authorisation Form

To help you in completing this form please ask a member of the Cheadles team

Please complete the details listed below in block capitals

Title (please tick) Mr Mrs Miss Ms Other

First Name _____

Surname _____

Email _____

Address _____

Postcode _____ **Telephone** _____

Date of Birth _____

Doctor _____

Surgery Address _____

Postcode _____ **Telephone** _____

I hereby nominate Cheadles Chemist to collect my prescription from the surgery on my behalf and to make arrangements for all my future prescriptions to be dispensed this way. This will include electronic transfer of my prescriptions and will allow my dispensed medicines to be delivered to my home or work address.

If I wish to change this arrangement, I will inform either party.

Signed _____ **Date** _____



E-Nova Healthcare Limited (trading as Cheadles Chemist) will hold information you provide on this form electronically and otherwise for administration purposes and for assessment and analysis to enable us to improve the products and services we offer. We will not disclose your information to third parties.

www.theadleschemist.com