Kepple Lane PHARMACY

Consent to participate in the **NHS New Medicine Service**

Title	Mr	Mrs	Miss	Ms	Other
Name					
Address					
				Post Code	
Telephone Number			Email		

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

- my doctor (GP) to help them provide care to me
- NHS England (the national NHS body that manages pharmacy and other health services) to allow them to make sure the service is being provided properly by the pharmacy
- NHS England, 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	