DUE TO COVID19 PANDEMIC

To: (Surgery Name)

REGARDING AUTHORISATION TO
ORDER AND/OR COLLECT MEDICATION.
(delete as appropriate)

I, (Patient's Name)

OF, (Patient's Address)

DATE OF BIRTH: (Patient)

HEREBY AUTHORISE, (Representative's Name):

OF, (Representative's Address)

TO ORDER AND/OR COLLECT MEDICATION ON MY BEHALF DURING THE CURRENT COVID19 PANDEMIC.
(delete as appropriate)

I CONFIRM THAT SHOULD I WISH THIS AUTHORISATION TO BE TERMINATED I WILL NOTIFY YOU IN WRITING

SIGNED……..(Patient)

DATE…….