**PATIENT AUTHORISATION**

**FOR THE PERSONS NAMED BELOW TO DEAL WITH ANY ISSUES RELATING TO MY MEDICAL CARE AT CROWN STREET SURGERY**

NAME: …………………….………………..………………………………………..………

ADDRESS: ………………………….……………………………………………………………

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Post Code: ………………………………………………………….………

DATE OF BIRTH: ……………………………………………………………………….……………….

I give my permission for Crown Street Surgery, 17 Crown Street, Swinton,

S64 8NB to allow persons named below to deal with any matters relating to my medication and medical care at the Surgery.

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| NAME | D.O.B. | RELATIONSHIP | CONTACT NOs. |
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Signed: …………………………………….......... Date: ………………………………..