Dr Suzanne Milligan
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The Milligan Family Practice

DATE: _____

NAME: _____

DOB: _____

ADDRESS: _____

_____

_____

I _____(insert 1st name) CONSENT TO HAVING MY

PRESCRIPTION/SOCIAL WELFARE CERT/LETTERS COLLECTED FROM THE SURGERY BY

_____ (insert name of nominated person).

I UNDERSTAND THAT IF A DIFFERENT PERSON IS GOING TO BE COLLECTING DOCUMENTS FOR ME FROM THE SURGERY THEN I NEED TO PROVIDE SEPARATE CONSENT FOR THEM.

SIGNED: _____