

**CONSENT FORM DISPENSARY DELIVERY SERVICE**

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| --- | --- |
| NAME: |  |
| DATE OF BIRTH: |  |
| HOME ADDRESS: |  |
| ALTERNATIVE SAFE LOCATION: |  |

Agree to have medication delivered by the Willingham by Stow Surgery to their home address. If the above named patient is not at the delivery address at the time of the delivery of medication, please leave in safe location stated above. Patient confirms that this location is safe from access by children or animals and takes responsibility of any medication left at the safe location.

PATIENT SIGNATURE: ­­…………………………………………………………

DATE: …………………………………………………………