

Consent for contact and Data Storage

Please read and complete this form prior to your appointment. This allows us to share your information with important people such as your GP, optician, and designated family members.

Name: _____
(please print)

I agree that Moor Eye Care Can contact me for medical care purposes via:

- Post
- Email
- SMS Text Message.
- Phone

I agree that Moor Eye Care can share my information with:

- My GP
- My Optician
- My Insurance company (if applicable)
- My friend or family. Please name _____.

I agree that Moor Eye Care can send me information about products and services they offer via:

- Post
- Email
- SMS Text Messages.

I agree that Moor Eye Care can use my information for medical research or outcome auditing purposes.

- Yes
- No

I understand that I can withdraw consent to any of the above options at any time.

Signature:

Name: _____
Date: _____