THE LINDUM MEDICAL PRACTCE

Name of Patient:	Date of Birth:
Address:	NHS No:
Mobile Phone No:	

TEXT MESSAGING OPT OUT

I would like to opt out of receiving text messages to the above mobile telephone number from The Lindum Medical Practice.

On withdrawing consent, I accept that I must give at least 5 working days' notice, quoting the above mobile number.

I understand I can change my mind at any point by completing a new Text Messaging Consent form.

I confirm that I understand the above statement and that I am the patient listed above.

Full Name:
Signature: Date:

ONE FORM PER PATIENT
OPT OUT MUST BE SIGNED BY ACTUAL PATIENT