

**Queenhill Medical Practice**

**Patient Participation Group**

Name: ….………………………………………………….………………………………………………………………………..

E-mail: ………………………………………………………………………………………..…………………………………….

I am a registered patient at QMP and I wish to receive information and newsletters from QMP PPG.

SIGNATURE: …………………………….…………………………………………………………………..……………….…

DATE: ………………………………………………………………………………………………….…………………………….

Please complete and return to QMP Reception or e-mail the QMP PPG’s Secretary (queenhillmedicalpracticeppgsec@gmail.com).

Any information you give here will be stored securely and not shared with QMP or another party.

If, at any time, you wish to have this personal data amended or deleted, please contact the QMP PPG’s Secretary.