Department of Social Protection - Treatment Benefit Consent Form

Please print or digitally complete this form and return it to Roches via email (info@roches.ie) or Post.

Name: _____ **PPSN:** _____ **DOB:** _____

I the undersigned, authorise *Roches Hair Solutions Ltd.* Hair Replacement provider to use my personal data for the purposes of checking my eligibility for Treatment Benefits and to allow for the processing of the payment claim in respect of treatments I have received.

I understand that I may revoke this consent at any time by contacting the Department of Social Protection.

Signature of client: _____

Signature on behalf of the provider: _____

Date: _____