PATIENT AUTHORIZATION FROM TO CALL/FAX PRESCRIPTION TO PREFERRED PHARMACY

Complete this form and sign bellow to authorize our staff to call or fax your prescription(s) to your preferred pharmacy on file with our medical office. Please notify us in witting of any changes to your standard pharmacy selection.

Please note that certain prescription mail-in programs require additional patient account information that we are unable to gain access to due to patient confidentiality. In that event, your prescription will be mailed to you directly at your home address on file.

PATIENT INFORMATION			
Patient First Name	Patient Last Name		Date of Birth
Patient Address	City	State	Zip Code
Home Phone	Work Phone	Cell Phone	

PHARMACY INFORMATION			
Pharmacy Name		Patient Account Number	
Pharmacy Address	City	State	Zip Code
Pharmacy Phone	Pharmacy Fax	Prescription Mail-In Program Yes No (Circle one)	

Patient Signature or Patient's Authorized Representative

Date

If signed by the patient's authorized representative, parent or guardian, please print name below and describe the relationship to patient

Patient Name of Authorized Representative

Relationship to Patient

For Office Use Only Date Received: _____ Received by: _____