PATIENT AUTHORIZATION FORM TO CALL/FAX PRESCRIPTIONS TO PREFERRED PHARMACY

Complete this form and sign below 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 writing of any change 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 regulations. 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 relationship to patient.

_____ _____

Printed Name of Authorized Representative | Relationship to Patient

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