Shawano Pharmacy
550-360 Broadway Ave
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USE FOR PATIENTS WHO ARE UNDER 18 YEARS OF AGE OR UNDER CARE OF A GUARDIAN

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CONSENT TO TRANSFER OF PHARMACY PROFILE

I, ________________________________ (**substitute decision maker**), authorize **SHAWANO PHARMACY** to obtain all prescription profile and information for __________________ ("**the patient**") relevant to their pharmacy needs. (Information includes personal health information, contact information, past medical and medication history and insurance/third party payer and any other information needed to provide pharmacy services).

I also hereby authorize **SHAWANO PHARMACY** to become the provider of medications and other pharmacy services to "the patient."

My signature means that:

- I have read this consent, or have it read to me and understand and agree its contents
- I understand the information collected from all sources will be held in strictest confidence
- I understand that I may revoke this consent by written statement at any time

NAME(PATIENT): _____________________ DATE OF BIRTH: ___________________

PHONE NUMBER: _____________________ TREATY #: ________________________

PHIN: _______________________________ ADDRESS: ________________________

____
(Signature of substitute decision maker)

____
Date (mm/dd/yy)

____
(Signature of Witness)

____
Date (mm/dd/yy)