Shawano Pharmacy
2 - 2521 McPhillips St.
Winnipeg, MB R2V 4M3
Tel: 1-833-742-9266
Fax: 1-833-496-0204

USE FOR PATIENTS WHO ARE UNDER 18 YEARS OF AGE OR UNDER CARE OF A GUARDIAN

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)**