CONSENT TO TRANSFER PHARMACY PROFILE

THIS TELECOPY IS **CONFIDENTIAL** AND IS INTENDED TO BE RECEIVED BY THE ADDRESSEE ONLY. IF THE READER IS NOT THE INTENDED RECIPIENT THEREOF, YOU ARE ADVISED THAT ANY DISSEMINATION, DISTRIBUTION OR COPYING OF THIS FACIMILE IS **STRICTLY PROHIBITED**.

I authorize **SHAWANO PHARMACY** to obtain all prescription profile and information relevant to my pharmacy needs. (Information includes personal health information, contact information, past medical and medication history, insurance/third party payer information, applicable Medication Administration Records/Forms 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. My signature means that:

- I have read this consent, or have it read to me and understand and agree with 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 (Printed)____________________________

Signature: __________________ **Date:** ___________________

Phone number: _______________________

Date of Birth: _____________________

PHIN/ Treaty #: ___________________

BOX #: _____________________ **Community:** ______________________