

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: _____

CURRENT PHARMACY: _____

PHARMACY'S ADDRESS: _____

(Signature of substitute decision maker)

Date (mm/dd/yy)

(Signature of Witness)

Date (mm/dd/yy)