CONSENT TO TRANSFER PHARMACY PROFILE

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: _____**