Office Policies - Pharmacy Selection and Adherence

Preferred Local Pharmacy Information:

____ located at this address

____ with the telephone number of

____________________________ for filling my prescriptions for all of my psychiatric medicine.

_____ I agree to use this pharmacy for any local prescription fillings

Preferred Mail Order Pharmacy Information:

____ located at this address

____ with the telephone number of

____________________________ for filling my prescriptions for all of my psychiatric medicine.

_____ I agree to use this pharmacy for any mail order prescription fillings

Additionally, by signing this agreement you agree to the following:

_____ I will only fill my prescriptions at the local pharmacy/mail order that I have designated on this form.

_____ I agree to update the office if I decide to use a new pharmacy and I will be required to sign a new form for any pharmacy changes.

_____ I authorize the provider and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my prescribed medications. I authorize my provider to provide a copy of this Agreement to my pharmacy, primary care provider and local emergency room. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

By signing this form, I am agreeing to the listed requirements for my local/mail order pharmacy.

Signature ____ Date: _______________________