Highway 36 and First Avenue
Atlantic Highlands
732-291-2900

Bayshore Pharmacy

PATIENT MEDICAL INFORMATION / CONSENT FORM

Please take a few minutes to complete this form. Information provided will be kept confidential and will help your pharmacist in reviewing your medication.

LAST NAME: _____ FIRST: _____ MI: _____ TITLE: _____

STREET: _____

CITY: _____ STATE: _____ ZIP: _____

BIRTHDATE: _____ SEX: _____

HOME PHONE: _____

WORK PHONE: _____

CELL PHONE: _____

E-MAIL: _____

PREFERRED METHOD OF CONTACT:

___ **HOME**
___ **WORK**
___ **CELL**
___ **MAIL**
___ **E-MAIL**

___ **I request my prescriptions be placed in a non-child resistant container** *(valid only if checked)*

DRUG ALLERGIES: ☐ **NO KNOWN DRUG ALLERGIES**

__ PENICILLINS __ SULFA ___ OTHER: _____

__ CODINE _____ _____

CONSENT TO ALLOW BAYSHORE PHARMACY TO USE AND DISCLOSE INFORMATION

1. CONSENT. By signing below, you consent to the use and disclosure of your protected health information by Bayshore Pharmacy, our staff, and our business associates for treatment, payment, and health care operations.

2. NOTICE OF PRIVACY PRACTICES. You certify that I have received a copy of Bayshore Pharmacy's Notice of Privacy Practices. You have the right to request the we restrict our uses or disclosures of your protected health information, which we are otherwise permitted to make, for treatment, payment and health care operations, although we are not required to agree to these restrictions. However, if we agree to further restrictions, they will be binding on us.

3. RIGHT TO REVOKE CONSENT. You have the right to revoke the consent in writing, except to the extent that we have taken action in reliance on it.

SIGNATURE: _____ DATE: _____

PRINT NAME: _____

Please print the names of any and all people authorized to request and/or receive PHI not covered by this authorization.

_____ _____

_____ _____