



## Ozanam Charitable Pharmacy Patient Consent Form

\_\_\_ I hereby give permission to authorized representatives of Ozanam Charitable Pharmacy to inspect my medical records whenever necessary to obtain pertinent information needed to solicit medications on my behalf from companies that manufacture or provide medications through patient assistance programs. I also authorize Ozanam to discuss me and my medical needs with my physician/prescriber when necessary. Additionally, I give permission to verify my income through the Department of Social Services, Social Security Administration or any other company, business or organization from which I receive income. This authorization is good as long as Ozanam is assisting me or until I revoke such.

\_\_\_ I agree that a copy of this form can be accepted as a valid consent to share information.

\_\_\_ If I do not sign this form, information will not be shared, and I will have to contact each agency, company, or organization individually to give them information about me that they need.

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### PATIENT RELEASE AGREEMENT

\_\_\_ I have given my pharmacy case worker truthful information about my health history, present health conditions, and drug allergies.

\_\_\_ I understand that the Ozanam Charitable Pharmacy is **unable to guarantee the availability of medication** and has been advised to maintain current prescriptions at a nearby retail pharmacy to ensure their availability to me.

\_\_\_ I understand that it may be necessary at times for the pharmacist to alter label directions regarding the strength of a medication, or the number of pills I must take to equal my prescribed dose. I will read and follow the label directions each time a medication is filled or refilled.

\_\_\_ I understand medications are dispensed in containers that **MAY NOT BE CHILD PROOF** and that it is my responsibility to keep them from children.

\_\_\_ I understand that the color of my pills may change from month to month.

\_\_\_ I give permission to representatives of ( \_\_\_\_\_ (agency)) to pick up my prescription from the Ozanam Charitable Pharmacy in Mobile.

\_\_\_ I give permission to Ozanam Charitable Pharmacy to disclose my protected health information to Dispensary of Hope, the Donors, and the agents, auditors and monitors of Dispensary of Hope and Donors.

I have listed below the names of two individuals who I authorize to pick up my medications for me in the event I am unable to pick them up for myself. **Proof of identity will be required.**

1. \_\_\_\_\_ 2. \_\_\_\_\_

**Patient Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_