

Pharmacy Medication Profile Request

AUTHORIZATION FOR RELEASE OF MEDICATION INFORMATION

PATIENT INFORMATION

Patient Full Name (Last, First, Middle Initial)

Date of Birth (MM / DD / YYYY)

Phone Number

Address (Street, City, State, ZIP)

PHARMACY INFORMATION

Pharmacy Name

Pharmacy Phone Number

Pharmacy Fax Number

Pharmacy Address (if known)

AUTHORIZATION

I, the undersigned patient, hereby authorize the pharmacy named above to release my current medication profile and prescription history to:

Restore Pain Center / Physician Practice Operations Group, PLLC

7306 US Hwy 11 Carriere, MS 39426

Phone: (601) 840-8004 Fax: (601) 510-5268

RECORDS REQUESTED

Please include the following (check all that apply):

- ☐ Current medication profile (all active medications)
- ☐ Active prescriptions
- ☐ Controlled substance prescriptions (if available)
- ☐ Prescription fill history (past 12 months)
- ☐ Other: _____

EXPIRATION & REVOCATION

This authorization expires 90 days from the date signed, or upon fulfillment of the above request, whichever occurs first. I understand that I may revoke this authorization at any time by notifying the pharmacy in writing, except where action has already been taken in reliance.

PATIENT SIGNATURE

Printed Name

Date (MM / DD / YYYY)

Patient Signature

Relationship to Patient (if signed by representative)