Personal Information

Name

Date of Birth Gender [ ] Male [ ] Female

Address

City State Zip Code

Primary Telephone [ ] Home [ ] Work [ ] Mobile

Secondary Telephone [ ] Home [ ] Work [ ] Mobile

Email Address

Allergy Information This information is **REQUIRED**

Do you have any drug allergies? [ ] Yes [ ] No/Not Sure

If you selected yes, please list your allergies here:

Common Allergies [ ] Penicillin [ ] Sulfa [ ] Tetracycline [ ] Codeine [ ] NSAIDs [ ] Phenytoin

Privacy Information

Who has permission to **discuss** your prescriptions with us if you can not?

Who has permission to **pick up** your prescriptions if you can not? [ ] Same as Above

Personal Preferences

Dispense medication in child resistant packaging? [ ] Yes [ ] No

Dispense medication with generic when possible? [ ] Yes [ ] No

Receive electronic notification when prescriptions are ready? [ ] Text [ ] Email [ ] None

Acknowledgement and Authorization

- I understand that I may revoke this authorization in writing at any time by sending a letter to Gibson Discount Pharmacy.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from Gibson Discount Pharmacy.
- I understand that if the person or entity that receives my PHI is not required to comply with federal privacy regulations, this information described above may be redisclosed and would no longer be protected by those regulations
- I understand that Gibson Discount Pharmacy will not receive compensation for using/disclosing my PHI pursuant to this authorization to Gibson Discount Pharmacy from a third party.

Signature of Patient or Personal Repressive Date

If signed by Personal Representative, explain your authority or relation to the patient