CHANGE OF PHARMACY

WE NEED A LOCAL PHARMACY IN ORDER TO PROCESS
PRESCRIPTIONS
NO MAIL ORDER PHARMACIES, PLEASE

PATIENT NAME: ____ DOB: ___________________

PHARMACY NAME: ____

PHARMACY ADDRESS: ____

____

PHARMACY PHONE: ____________________________ FAX: __________________________

SIGNATURE: ____ DATE: _____/_____/_____

WE WILL BE ABLE TO SEND PRESCRIPTIONS TO ONLY **ONE** PHARMACY. IF YOU NEED TO CHANGE PHARMACIES, YOU WILL NEED TO COMPLETE AND RETURN A CHANGE OF PHARMACY FORM OR CALL THE PHARMACY YOU HAVE PREVIOUSLY CHOSEN AND HAVE THE PRESCRIPTION TRANSFERRED. WE WILL CONTINUE TO USE THE ABOVE PHARMACY UNTIL YOU NOTIFY US IN WRITING.