PATIENT CONSENT FOR MY MEDICATIONS REVIEW

I authorize, Antonella Martino to conduct a review of my medication regimen. I understand that any recommended changes about the use of my medications should not be initiated without prior consultation with my physician(s).

By signing this form I give permission to Antonella Martino for contacting my physician(s) if necessary about medication-related concerns that may be discovered in the course of this review for the purpose of improving my overall health care outcomes.

I understand that this consent form is revocable upon written notice to The Health Consultant Pharmacists of America except when action has already been taken.

I authorize The Health Consultant Pharmacists of America to maintain a copy of my health information and medication history for the purpose of monitoring and following up when necessary.

I understand that every effort will be made to maintain the confidentiality of my private information. The obtained information will not be shared with anyone else except my legal representative, if assigned as listed below.

CONSENT FOR THE RELEASE OF MEDICAL INFORMATION

I understand that the pharmacist that completes my medication review may need to confidentially discuss my care with my physician(s) and/or other health care providers or with my insurance company or medications plan, for the ultimate purpose of improving my healthcare outcomes and medication safety.

I give my permission to The Health Consultant Pharmacists of America to request certain medical/health information from other members of my health care team.

I may revoke this consent form at any time by providing written notice to The Health Consultant Pharmacists of America, unless this medical information has been already released prior to my revocation.

Print Your Name _____

Your Signature _____

Print Legal Representative Name if applicable _____

Signature of Legal Representative if applicable _____

Date _____