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.