Mayfair Pharmacy

128 - 6707 Elbow Drive SW Calgary, AB T2V 0E3

P: 403.259.6893 F: 403.255.1971 E: mayfairpharmacy@pharmachoice.ca

Complete this form to provide consent and authorization to disclose and/or distribute information, prescriptions, prescription receipts, or medication records .

I, _____, the ("Patient"), hereby give my consent and authorize the staff of Mayfair Pharmacy on this date of _____,to allow the Authorized Persons stated below to perform the Authorized Tasks stated herein on my behalf for the Authorized Time indicated below.

Authorized Persons:

1. _____ Relationship: _____
2. _____ Relationship: _____
3. _____ Relationship: _____

Authorized Tasks (initial beside each applicable statement):

_____ Picking up of my medications

_____ Ordering of my medication refills

_____ Picking up my annual prescription tax receipt

_____ Other specified activity: _____

Authorized Time (initial one selection and complete blanks below if required):

_____ One time on _____ (print date)

_____ 6 months

_____ 1 year

_____ Indefinitely

_____ Specified time: _____

By signing below, I understand that I have provided my consent and authorization to the staff of Mayfair Pharmacy as indicated herein. I also understand that I may change or cancel the authorization stated above at any time.

Patient Signature: _____

Patient Name (Print): _____

Staff Member Initials:_____

Staff of Mayfair Pharmacy reserve the right to deny the Authorized Persons for any reasons whatsoever. Staff of Mayfair Pharmacy also reserve the right to have a pharmacy staff member witness the Patient signing this form.