The Medicine Shoppe PHARMACY

Caregiver Support

Caregiver Consent Form

Patient Name: _____

Health Care Number: _____

This form provides my consent for the pharmacy to provide and share my health information to my designated caregiver named on this document.

This authorization is effective for the following period:

From: _____ To: _____
dd/mm/yy dd/mm/yy

Authorized
Caregiver Name: _____

Relationship
to Patient: _____

Caregiver
Phone Number: _____

Caregiver
Email Address: _____

Patient
Signature: _____ Date: _____

Pharmacist
Signature: _____ Date: _____