

Authorization for Medication Review

I hereby authorize Courtyard Pharmacy Staff to review my medication regimen. I understand that any changes about the use of my medications should not be initiated without the authorization of my physician(s).

By signing below, I give Greta Goldshtein, PharmD and Courtyard Pharmacy Staff, permission to contact my physician(s), if necessary, about medication-related concerns that may be discovered in the course of the review.

I understand that this consent is revocable upon written notice to Courtyard Pharmacy except to the extent that action has already been taken on this authorization. YES _____ NO _____

I authorize Courtyard Pharmacy to maintain a copy of my health profile and medication-related recommendations for the purpose of follow-up and monitoring.

I understand that every effort will be made to maintain the confidential nature of my private health information. Information about this review will not be shared with anyone except my legal representative without my written consent.

Signature of Patient/Legal Representative:	Date:
Name of Legal Representative, if other than patient:	
Print Patient Name	Phone number: