

Partners in Recovery

Pharmacy Medication Release Form

Name of Consumer _____

Consumer ID # _____

Consumer Date of Birth _____

I have been instructed in the proper use of the medication(s) given to me, including how much of the medication(s) to take, how often to take the medication(s), and what the medication(s) is/are used for. By signing this document, I accept responsibility for the proper storage and use of the medication(s).

I understand that medication(s) dispensed in Bubble Packs will be in containers that are not child resistant (childproof).

Signature of Responsible Party receiving medication(s)

Date

Print Name of Party receiving medication(s)

Signature of Health Care Representative

Date

Please fax the signed form to name of pharmacy that provides bubble packs with fax number.

Place a copy of this signed form in the consumer's Medical Record at the clinic.

Pharmacy name, address & phone numbers listed here.