RIT & Wegmans
Prescription Delivery Program



> Fill out all paperwork in blue or black ink legibly and return completed paperwork to the RIT Health Center or Wegmans Marketplace Pharmacy. Please include **YOUR** cellphone number, not your parents or guardians.

- **All new and returning students must complete all paperwork at the beginning of EACH fall semester.**

> For security purposes, once your paperwork is turned into Wegmans, all credit card requirements and updates will be sent in a text with link. You will have to submit your payment method before we can deliver.

- **You will have 24 hours to complete the set up or the link expires.**
- **WE CAN NOT DELIVER WITHOUT A PAYMENT CARD ON FILE!**

> If you have filled out all required paperwork and updated payment on file, your prescriptions will automatically be delivered weekly to the RIT Health Center every Monday and Thursday between 2-4 PM.

- **You will receive text messages from our pharmacy. Payment updates, prescription updates, when your prescription is ready and when your prescriptions have been delivered to RIT. Read the messages fully.**
- **If you pick up prescriptions in-store, the charge card on file can not be used. It turns into a normal transaction and has to be processed with an actual credit/debit card or cash.**
- **You must call if you do not want your prescriptions delivered - this includes breaks and holidays.**
- **You have 10 days to pick up prescriptions from RIT Health Center (not controlled substances) or they will be returned to Wegmans.**

KEEP THIS FORM AS REFERENCE

Wegmans Marketplace Store #062

650 Hylan Drive

Rochester NY, 14623

Please call (585) 424-7350 with any questions!

Wegmans Pharmacy # 62
650 Hylan Drive
Rochester, NY 14623
Phone: 585-424-7350
Fax: 585-424-7540

Patient Information (please print clearly)

Gender ◯ Female ◯ Male

Student Name

Last First MI

Date of Birth

Month Day Year

Medication Allergies _____

Graduation Year _____

Home Address (For insurance purposes)

Street

City

Preferred Contact Information

Cell Phone Number

email (if hearing impaired only)

Insurance Information

Name of Insurance_____

Member/ Subscriber ID Number_____

RX Bin Number_____

RX PCN Number (if Provided)_____

RX Group Number_____

Member/Pharmacy Services number on back of insurance card_____

Wegmans Pharmacy # 62
650 Hylan Drive
Rochester, NY 14623
Phone: 585-424-7350
Fax: 585-424-7540

Authorization for Release of Medication

I authorize Wegmans Food Markets, Inc. to release my prescription medication to the RIT Student Health Center. The Health Center will hold my prescription until I pick it up or for 10 days, whichever is less.

Wegmans Pharmacy is unable to take prescription medication back once it has left Wegmans Pharmacy counter.

Patient Information (please print clearly)

Student Name _____
Last First MI

Date of Birth _____ / _____ / _____
Month Day Year

Contact Information

_____
Cell Phone Number Other Phone Number

_____
email

Signature

X _____
Date

WEGMANS PHARMACY
Authorization for Disclosure of Medical Information

I, _____, hereby authorize and request Wegmans Pharmacy
[Print Your Name]
to disclose my individually identifiable health information to: [List name and address of person to whom information may be disclosed]
Name: _____
Address (Street, City, State, Zip): _____
_____

Such authorized disclosures by Wegmans Pharmacy may include all of my individually identifiable health information that Wegmans Pharmacy maintains, creates, or otherwise obtains for purposes of filling my prescriptions or providing me with pharmacy services. This information may include, but is not limited to, my name, address, my physician's name, medical condition and other prescription information. I further understand that the information disclosed by Wegmans Pharmacy pursuant to this authorization may be used and disclosed by the recipient and may no longer be protected by the Federal Privacy Regulation (45 C.F.R. pt 164).

I understand and agree that this authorization shall expire **two years** from the date of my signing this authorization or two years from the date this authorization is received by Wegmans Pharmacy, whichever is sooner. If I wish to have the authorization expire at an earlier date, I can do so in the lines below. The following are criteria or limitations that I wish to make regarding this authorization: _____
_____.

I understand and acknowledge that Wegmans Pharmacy may not condition treatment, payment, or enrollment for benefits on whether I sign this authorization, unless Wegmans Pharmacy's treatment of me is related to a research project for which my information is required or Wegmans Pharmacy's provision of health care is for the purpose of creating protected health information for a third party to whom the information will be disclosed.

I understand that I have the right to revoke this authorization, at any time, by sending my written revocation to: Wegmans Chief Privacy Officer, P.O. Box 30844, Rochester, New York 14603-0844. However, the revocation will not apply to the extent that Wegmans Pharmacy has taken action in reliance upon this authorization.

_____ _____
Patient's Signature Date

_____
Patient's Printed Name

_____
Patient's Date of Birth

Pharmacy: Send by Intercompany Mail to Pharmacy Office

Customers can either give this to Pharmacy or mail this authorization to:
Wegmans Food Markets, Inc.
Pharmacy Office
1500 Brooks Avenue, P.O. Box 30844
Rochester, New York 14603-0844