Wegmans Pharmacy #062
650 Hylan Drive
Rochester, NY 14623
Phone: (585) 424-7350

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 #062
650 Hylan Drive
Rochester, NY 14623
Phone: (585) 424-7350

Patient Information (please print clearly)

Legal Name: _____
Last First MI

Preferred Name: _____

Sex: _____ **Preferred Pronouns:** _____

Gender: _____

Date of Birth: _____ / _____ / _____
Month Day Year

Medication Allergies: _____

Contact Information

_____
Street

_____
City State Zip Code

_____
Cell Phone Number

Signature

X _____
Date

Pharmacy 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 Delivery Service Credit Card Authorization

- **This form authorizes the use of a credit card to perform transactions that result in delivery to patients from the store.**
- **If you wish to fill prescriptions for multiple patients, please fill out multiple forms**

Patient Information:

First Name **MI** **Last Name** **Suffix** **Date of Birth (MM/DD/YYYY)**

Permanent Address **Gender:** ○ Male ○ Female

City **State** **Zip Code**

Email Address (for shipping notification) **Preferred Phone Number**

Check one: ○ **Home** ○ **Cell**

Delivery Information (if different from address above):

Delivery Address (only if different than permanent address)

City **State** **Zip Code**

Payment Information:

Credit Card Number **Expiration (MM/YY)** **Card Type**:

○ **American Express®** ○ **Discover®** ○ **MasterCard®** ○ **Visa®**

Card Holder's First Name **MI** **Card Holder's Last Name** **Suffix** **Date of Birth (MM/DD/YY)**

Billing Address

City **State** **Zip Code**

Please choose **one** of the following options:

○ Place the credit card information above on file for recurrent use for **only the patient associated with this order.**

○ Place the credit card information above on file for the recurrent use for the **patient associated with this order and future orders for additional patients.** (List additional patients below)

Additional Patients:

First Name MI Last Name Suffix Date of Birth (MM/DD/YYYY)

First Name MI Last Name Suffix Date of Birth (MM/DD/YYYY)

First Name MI Last Name Suffix Date of Birth (MM/DD/YYYY)

By signing below, I authorize Wegmans to charge the credit card identified above for this order and all future orders associated with this patient and additional patient(s) listed above, and that at my verbal request; Wegmans may update my billing address and/or credit card expiration date on file.

Cardholder Signature_____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: _____
_____

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

<u>Please mail this authorization to</u>:
Wegmans Food Markets, Inc.
Chief Privacy Officer
P.O. Box 30844
Rochester, New York 14603-0844