MUSHKEGOWUK O.M.A PRIMARY CARE
PATIENT PHARMACY CONSENT FORM

Consent to Obtain Health and Medication Records from Pharmacy

I _____ hereby authorize:
(Please print name of patient / substitute decision maker above)

Name of Pharmacy:			
Address:			
Phone #:		**Fax#:**	

Name of Pharmacy:			
Address:			
Phone #:		**Fax#:**	

To disclose any personal health information as well as current and past medication information.

Disclose To Following Recipient:

Mushkegowuk O.M.A Primary Care at 11 Elm St. N. Timmins, ON, P4N 6A3.
Phone: 705-269-6662, Toll free: 1-855-687-4429, Fax: 1-888-777-5708

Patient Name: _____DOB: _____

Address:_____City:_____

Postal Code:_____Phone:_____

I understand that this personal health information is to be used ONLY by the recipient for the purposes of providing primary care. I hereby waive all claims against Mushkegowuk Health O.M.A and the Primary Care provider, in connection with my now authorized disclosure of this personal health information.

Signed by Patient: _____

Signed by Substitute Decision Maker: _____

Date: _____