AUTHORIZATION FOR MEDICATION REVIEW

I Hereby authorize Karen H Wooten, RPh 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 Karen H Wooten or Medication Therapy Management Solutions, LLC permission to contact my physician(s), if necessary about my medication-related concerns that may be discovered in the course of the review.

I understand that this consent is revocable upon written notice to Karen H Wooten except to the extent that action has already been taken on this authorization. YES NO (circle one)

I authorize Medication Therapy Management Solutions, LLC 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

Print Patient Name

Consent for Release of Medical Information

Pharmacy Name: _____

Pharmacy Address: _____

I understand that the pharmacist may need to discuss my care with my physician and other health care providers, as well as with my insurance company if required to obtain reimbursement. I do hereby grant permission for the above-named pharmacy to request certain medical/health information from other members of my health care team. This information will be shared with my pharmacist confidentially and specifically for my care.

By signing my name below, I acknowledge receiving a copy of this document and agree to the sharing of my health information between the pharmacist and other members of my health care team. I understand that I may revoke this consent at any time by providing written notice to the above-named pharmacy. I also understand that any release of medical information prior to my revocation shall not constitute a breach of my rights to confidentiality.

_____	_____
Date	Print Patient Name
_____	_____
Patient/Caregiver Signature	Patient Date of Birth
_____	_____
Relationship of Caregiver to Patient	Address
_____	_____
Pharmacy Representative	City, State, Zip Code

Source: American Pharmacists Association. *Diabetes Management Services: A Pharmacist's Resource Guide.* Washington, DC: American Pharmacists Association; 2004:46. Form 1.

CONFIDENTAL **CONFIDENTIAL**

Medication Therapy Management Solutions, LLC
1567 Weiskopf Dr
Columbus, Ohio 43228

REQUEST FOR RELEASE OF PHARMACY RECORDS

Dear Pharmacist,

This form is to request and authorize the release of a print-out indicating medications dispensed during the past 6 months for the client listed below. The purpose of Medication Therapy Management Solutions, LLC is to work with clients in their home to optimize pharmaceutical care and reduce the risk of adverse events. The requested information will be held in confidence and used for patient education and monitoring of compliance.

PATIENT NAME: _____

Date of Birth: _____

Address: _____
_____

Social Security Number: _____

I, _____, authorize the release of the above requested information to Medication Therapy Management Solutions, LLC for the above stated purpose.

Patient Signature: _____ Date: _____

Please forward the requested information by fax to the attention of: Karen H Wooten, RPh.

Medication Therapy Management Solutions, LLC.
1567 Weiskopf Dr
Columbus, Ohio 43228
PH: 614-306-5375
FAX: 614-278-9945