anewhealth

ExactCare Pharmacy Assessment Authorization & Consent Form

Patient Information

Patient Full Name: _____

Date of Birth: ____ / ____ / _____

Patient Confirmation

Please answer the following questions:

1. Are you able to make your own healthcare decisions?

☐ Yes

☐ No

If No, please stop. A legal healthcare decision-maker (e.g., healthcare power of attorney or legal guardian) must provide authorization.

Pharmacy Enrollment Consent

2. Do you authorize ExactCare Pharmacy to transfer your prescriptions from your current pharmacy to ExactCare Pharmacy as needed to provide pharmacy services?

☐ Yes

☐ No

Medication History Consent

3. Do you authorize ExactCare Pharmacy to obtain your medication and prescriber history through SureScripts and other available medication history services?

This information helps ensure your medication list is accurate and may include prescriptions recently filled at your current pharmacy.

☐ Yes

☐ No

Authorization for Another Person to Complete the Assessment

I authorize the individual listed below to complete the ExactCare Pharmacy assessment on my behalf, provide information related to my medications, health conditions, providers, and pharmacy needs, and receive protected health information and other personal information from ExactCare Pharmacy as necessary to complete the assessment process.

Authorized Representative Name:

Relationship to Patient:

Phone Number:

Email:

Patient Consent

By signing below, I acknowledge that:

- I certify that I have the capacity to make my own healthcare decisions.
- I voluntarily authorize the individual named above to complete the ExactCare Pharmacy assessment on my behalf.
- I understand this authorization is limited to the assessment and enrollment process and does not grant authority to make ongoing healthcare decisions unless otherwise authorized by applicable law or separate legal documentation.
- I consent to the transfer of my prescriptions to ExactCare Pharmacy, if applicable.
- I consent to ExactCare Pharmacy obtaining my medication and prescriber history through SureScripts and other available medication history sources.
- I understand that I may revoke this authorization at any time by notifying ExactCare Pharmacy in writing. Any actions already taken before I cancel it will still be valid.

Patient Signature

Signature: _____

Printed Name: _____

Date: ____ / ____ / _____

You can send completed forms to us via:

Email: Privacy@anewhealthrx.com

Fax: 216-369-2201, Attention: Compliance

Mail: ExactCare Pharmacy Attention: Compliance 8333 Rockside Road Valley View, OH 44125