Authorization for Automated Messaging

PRINT AND COMPLETE THIS AUTHORIZATION AND RETURN TO TOTAL HEALTH CARE PHARMACY.

ALL INFORMATION WILL REMAIN CONFIDENTIAL

Please Initial:

_____ I authorize **Total Health Care Pharmacy** to send me txt messages when my prescription is ready and/or reminders for when medications are due. Message and data rates may apply.

_____ I authorize **Total Health Care Pharmacy** to enroll me in **MED SYNC**, whereby all my maintenance medications will be processed on the same day every month to save me multiple trips to the pharmacy.

_____ I authorize **Total Health Care Pharmacy** to **AUTOMATICALLY DELIVER** my medications for me when they are ready. I understand that I do not need to be present for delivery, and the driver is authorized to leave the medication at my place of residence.

_____ I authorize **Total Health Care Pharmacy** to monitor my Diabetes therapy in collaboration with other providers in the clinic.

_____ I authorize **Total Health Care Pharmacy** to send me promotional messages about new programs, promotions, patient satisfaction surveys, etc. through txt message or phone call. Message and data rates may apply.

_____ I understand that I may remove my authorization for any or all of the above items at any time and that I must notify a staff member of **Total Health Care Pharmacy** to remove or make changes to any of the information provided.

Please update your contact information:

Name: _____

Date of Birth: _____ Drug Allergies: _____

Cell Phone: _____

Address: _____

Sign: _____ Date: _____