



# Patient Enrollment Form

New Enrollment  Update Reminder

Name \_\_\_\_\_ Birthday Date \_\_\_\_\_

Email Address(s) \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Home Phone Number \_\_\_\_\_ Cell Phone Number \_\_\_\_\_

What type of alerts would you like to receive?  Take  Refill  Appointment  Check

Please send my reminders via (check all that apply)  Phone Call  Text Message  E-mail

If the need should arise, do we have your permission to contact you by any of the above methods with timely and relevant health information?  Yes  No

### Prescription Medication

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Frequency – How often and at what time(s) do you need a reminder?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### OTC Medication (Aspirin, Allergy, etc)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Frequency – How often and at what time(s) do you need a reminder?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Vitamins and Supplements

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Frequency – How often and at what time(s) do you need a reminder?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Additional Reminders (Blood sugar readings, blood pressure, flu shots, etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Frequency – How often and at what time(s) do you need a reminder?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

By my signature on the back of this form, I attest the information above is true and correct. I also understand it is my responsibility to contact the pharmacy if there is any change in the way I take my medication. Further I acknowledge that I have received the My Dose Alert Privacy and Terms of Use. Text messaging and airtime charges may apply depending on your phone provider contract.

**(OVER)**

**AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION**

PHARMACY DEVELOPMENT SERVICES AND INTELECARE WILL NOT SHARE YOUR PERSONALLY IDENTIFIABLE INFORMATION WITH ANY THIRD PARTY WITHOUT YOUR CONSENT UNLESS REQUIRED BY LAW OR WHEN NECESSARY TO PROTECT OUR RIGHTS AND/OR TO COMPLY WITH A JUDICIAL PROCEEDING, COURT ORDER OR LEGAL PROCESS SERVED ON US. WE AND OUR PARTNERS MAY, FROM TIME TO TIME, CALL OR SEND YOU INFORMATION THAT MAY BE OF INTEREST TO YOU BASED ON YOUR HEALTH PROFILE AND ACTIVE REMINDERS. YOU CAN OPT-OUT OF RECEIVING THESE COMMUNICATIONS AT ANY TIME.

**Authorization.** This is an authorization by \_\_\_\_\_ (the "Patient") for use and disclosure of the Patient's health information created or received by Pharmacy Development Services (the "Provider").

**Information That May Be Disclosed.** Information that may be disclosed or used by the Provider under this authorization includes information regarding the Patient's medications.

**People Who May Disclose.** The people who may use or disclose the Patient's medical information pursuant to this authorization are any employee or other representative of the Provider or your pharmacy. Patient acknowledges that the Provider will store Patient's information on Provider's Marketing Solution Center's My Dose Alert System and Intelecare.

**People Who May Receive.** The people who may receive the Patient's information are the Patient and any third person who has access to the Patient's personal property (i.e., the Patient's telephone, computer, etc.) through which the Provider will provide alerts to the Patient through My Dose Alert. Patient acknowledges that Patient has sole control and responsibility over determining which, if any, third persons have access to the personal property on which Patient will receive alerts from Provider. Therefore, Patient authorizes Provider to release Patient's information to any such third persons.

**Purposes.** Information disclosed or used under this authorization may be used for the purposes of alerting the Patient through The Marketing Solution Center and My Dose Alert of the time that the Patient should take his or her medication or any other related or relevant health information or in-store events. The Pharmacy and Provider will alert the Patient through The Marketing Solution Center or the My Dose Alert System via the mode of communication requested by the Patient, including, but not limited to, telephone calls, text messages, or electronic mail.

**Redisclosure.** Information disclosed under this authorization will be given to recipients who may redisclose the information and those later disclosures may not be protected by law.

**Expiration and Revocation.** This authorization will continue in effect until the earlier of the death of the Patient or the revocation of this authorization by the Patient. The Patient may revoke this authorization in writing at any time, except to the extent that the Provider has acted in reliance on this authorization. Revocation may be made in writing delivered to the Provider.

**Notification of Breach of Patient's Information.** In the event that any unsecured personal health information of Patient, as defined by 42 U.S.C § 17932(h)(1), is breached, or is reasonably believed by the Pharmacy or Provider to have been breached, the Pharmacy or Provider will notify the Patient as required by applicable law.

**Patient Access and Refusal.** The Patient may inspect or copy the information disclosed under this authorization by delivering a written request to the Provider. The Patient may refuse to sign this authorization.

By signing below, the Patient authorizes the Pharmacy and Provider to use and disclose information as described in this authorization.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Name (Please Print)