United Way
United Way of Dane County

WISCONSIN PHARMACY QUALITYCOLLABORATIVE
an initiative of the pharmacy society of wisconsin

Authorization for Comprehensive Medication Review and Assessment

Patient Initials	
_____	I hereby authorize _____ Pharmacy to review my medications. I understand that any changes to my medications will not be made without the permission of my physician(s).
_____	By signing below, I give _____ Pharmacy permission to contact my physician(s), if necessary, about medication-related issues that were discussed during the appointment.
_____	I understand that I can withdraw this consent at any time by contacting _____ Pharmacy except for when the medication-related issues have already been discussed with my physician(s).
_____	I authorize _____ Pharmacy to keep a copy of my health profile and medication-related recommendations for the purpose of follow-up and monitoring.
_____	I authorize _____ Pharmacy to send a copy of their report and recommendations to the case manager so that he or she can be a source of support to me in making the changes approved by my physician.
_____	Some of the information collected in this review may be used by United Way or Pharmacy Society of Wisconsin for reporting or publication purposes. Any data from my visit that will be used for this program will be de-identified so it cannot be linked to my personal health information. I understand that every effort will be made to keep my personal health information private and confidential.

Signature of Patient:	Date:
Print Patient Name:	
Patient Address and Phone Number:	
Pharmacist Name and Signature:	Date: