|  |
| --- |
| **PATIENT INFORMATION** |
| Patient Name: (Last, First, Middle) | My Health LA ID: |
|  |  |  |  |
|  |  |  |  |
| DOB: | Gender: (Please check one)[ ]  Male  [ ]  Female | Allergies:  |
| Address: | Suite, Floor, or Apt. # |
|  |  |
| City: | State: | ZIP Code: |
|  |  |  |
| Home Phone #: | Mobile Phone #: | Language Preference: |
|  |  |  |
|  |  |
| **CLINIC INFORMATION** |
| Clinic Name:  | Provider Name:  |
|  |  |
| Address: |
|  |
| City: | State: | ZIP Code: |
|  |  |  |
| Phone #: | Fax #: | Email: |

|  |
| --- |
| **DELIVERY PREFERENCE** |
| Specialized Packaging: (Please check one) | [ ]  Safety Cap | **OR** | [ ]  No Safety Cap (Easy Open Lid) |
| Delivery Option (Please check one): |  |
| [ ]  Patient Home | **OR** | [ ]  Clinic |

### Patient Attestation

### I understand, by my signature below, participation in the mailing program is voluntary and dependent upon providing a valid LA County address. Failure to provide a reliable address will disqualify me from the mailing program, and subsequently I will need to arrange for medication pick-up on my own. I also understand it is my responsibility to request medication refill(s) using the automated telephone refill system (IVR) in a timely manner.

###  Additionally, I understand that it is my responsibility to update my address with the pharmacy if my preferred mailing address changes. By signing this consent form, I am indicating that I fully understand the attestation and that I agree to have prescriptions mailed to the address specified above.

**Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**