Authorization For Medication Review

CONTINUAL CARE™
Medication Therapy Management

I hereby authorize _____ to review my medication regimen. I understand that any changes about the use of my medications should not be initiated without the authorization of my physician(s).

By signing below, I give _____ or _____ permission to contact my physician(s), If necessary, about my medication-related concerns that may be discovered in the course of the review.

I understand that this consent is revocable upon written notice to _____ except to the extent that action has already been taken on this authorization. ☐ YES ☐ NO

I authorize _____ to maintain a copy of my health profile and medication-related recommendations for the purpose of follow-up and monitoring,

I understand that every effort will be made to maintain the confidential nature of my private health information. Information about this review will not be shared with anyone except my legal representative without my written consent.

Signature of Patient/Legal Representative	Date
Print Patient Name	