Consent for Medication Packaging Services to be provided by Mobile Pharmacy Solutions

Through my written consent below I am now requesting that Mobile Pharmacy Solutions package my medications, which Mobile Pharmacy Solutions has received valid prescriptions for, to help me with taking them correctly. I acknowledge that I have been informed of the following:

(1) How the medications will be packaged together;

(2) Which medications are not allowed to be packaged together;

(3) How to take the packaged medications;

(4) How to identify each medication in the package; and

(5) What to do if a medication is stopped or changed.

This consent is effective as of the date first written below. I am aware that I may revoke this consent or contact a pharmacist at anytime by calling, writing, or faxing to the following:

Mobile Pharmacy Solutions, Inc.

644 Ellicott Street, Suite 104

Buffalo, NY 14203

Phone: 716-247-5300

Fax: 716-716-681-2270

_____ _____/_____/_____

Patient Name (Print) Date

_____ _____

Consent Given By(Print) Signature
(Patient or Authorized Representative)