

Patient Consent for Pharmacist Consultation Services

Preventative Pharmacy Services for California

PATIENT INFORMATION

Name	_____	Date of Birth	_____
Gender	_____	Phone	_____
Email	_____	Primary Care Provider	_____
Address	_____		

Allergies _____

CONSENT AND ACKNOWLEDGMENT

1. I voluntarily request and consent to pharmacist consultation services provided through PharmDPrescriptions.com, including medication review, patient education, recommendations, and care coordination related to medication therapy.
2. I understand that PharmDPrescriptions.com is a consult-only service and does not dispense medications, provide emergency care, replace routine medical care, or establish a physician-patient relationship.
3. I understand that recommendations may require follow-up with a physician, nurse practitioner, physician assistant, or other authorized prescriber.
4. I understand that services may be provided by telephone, secure electronic communication, video, or other remote means, and that remote consultation relies on the accuracy and completeness of the information I provide.
5. I authorize PharmDPrescriptions.com, when appropriate for care coordination, to communicate with my healthcare providers regarding medication-related recommendations or concerns.
6. I understand that consultation services are educational and supportive in nature, that recommendations are based on available information and professional judgment, and that no specific outcome has been promised.
7. I acknowledge that I am responsible for seeking urgent or emergency medical attention by calling 911 or going to the nearest emergency department for severe or life-threatening symptoms.
8. I release pharmdprescriptions.com, its affiliates, officers, directors, employees, and agents from all liability arising from my receipt of the services provided.

PATIENT ACKNOWLEDGMENT

By signing below, I confirm that I have read and understand this consent form, that I have had the opportunity to ask questions, and that I agree to receive pharmacist consultation services from PharmDPrescriptions.com under the terms stated above.

Signature: _____ Date: _____

Printed Name: _____ Relationship (if applicable): _____