PARKS PHARMACY COMPOUNDING

PRESCRIPTION TRANSFER FORM

PRINT NAME: _____

ADDRESS: _____

CITY, STATE, & ZIP CODE: _____

PHONE(S): _____

DOB: _____ **ALLERGIES:** _____

SS#: _____ **TYPE OF INSURANCE:** _____

INSURANCE BIN#: _____ **CARDHOLDER ID#:** _____

GROUP#: _____ **PCN#:** _____

RX#	NAME OF MEDICATION	DOCTOR'S NAME & PHONE NUMBER	PHARMACY NAME & PHONE NUMBER

This form also serves as a limited power of attorney, is specific to and only for the purpose of providing signatures for the receipt of medicines from Parks Pharmacy. This agreement gives Parks Pharmacy representatives power to sign my name to the signature logs for receipt of my medicines.

PARKS PHARMACY MONTGOMERY: 334-264-1416 – HAYNEVILLE 334-548-6240 **FAX: 334-323-5663**

PATIENT'S SIGNATURE: _____ **DATE:** _____

PARKS PHARMACY REP: _____ **DATE:** _____