PRESCRIPTION REFILL AUTHORIZATION

The Prescription Refill Authorization form allows us to refill your medications by phone or fax.

Understand that at times Pharmacists may ask for relevant information about your diagnosis, treatment plan, compliance and or plans regarding your treatment.

Most pharmacists and practitioners run CURES on patients who receive controlled medications. This is a statewide database that reports the drug, quantity, dispensing pharmacy and date that a prescription was filled.

We strongly urge you to fill all of your medications at one pharmacy.

Due to recent problems with medication availability and price differences between pharmacies, this may not always be possible.

If it is not possible to fill your medications at one pharmacy, please make your best effort to let us know where you will regularly be filling your prescriptions.

PRESCRIPTION REFILL AUTHORIZATION

Robyn K. Sato, D.O.
150 Laguna Rd. Ste A
Fullerton, CA 92835
Phone: 714-738-5525 & Fax: 714-738-1352

Purpose: This document allows our medical practice permission to refill medications in compliance with HIPPA.

Patient Name: _____
Patient DOB: _____

I give my permission to the practitioners and staff of this medical office to initiate and renew medical prescriptions by use of telephone and fax. I understand that these are not considered completely secure means of communication under Federal law.

I authorize any pharmacy filling (or having filled) a prescription from this office to discuss my medication with Dr. Sato or her staff, including my entire medication profile, which may be disclosed by letter or fax.

My prescriptions will be placed with the following Pharmacy or Mail Order Pharmacy:

_____
Name City Telephone

_____
Name City Telephone

_____*I understand that I must give two business days' notice for routine refill of prescriptions, by fax: (714) 738-1352.*

_____ *I understand mail order prescriptions often take several weeks to process in the mail.*

_____ *I understand that it is my responsibility to ensure that my prescription is sent to the pharmacy and that there are risks in receiving medications via mail order: delivery may not be secure, medications may not make it to the correct location on time, medications may be stolen or delivered to the wrong location and that medications may not be replaced.*

_____ _____
Patient Date Witness Date