Psychiatry Associates of KC
8900 State Line Road, Suite 380
Leawood, KS 66206
(913) 385-7252. p
(913) 385-2412. f

## APPOINTED PHARMACY CONSENT

I, _____, do hereby:
Patient Name (Print)

☐ I authorize all my medications prescribed by my physician to be electronically sent to the pharmacy listed below.

☐ I agree to allow pharmacist to contact physician listed above to discuss my treatment if necessary, so that my prescriptions can be filled.

I understand that I may withdraw this consent at any time, either verbally or in writing except to the extent that action has been taken in reliance on it. This consent will last while I am being treated at PAKC. This consent will expire 36S days after my last treatment, unless the physician specified above is otherwise notified by me.

I understand that the records to be released may contain Information pertaining to psychiatric treatment and/or treatment for alcohol and/or drug dependence. These records may also contain confidential information about communicable diseases including HIV (AIDS) or related Illness. I understand that these records are protected by the Code of Federal Regulations• Title 42 Part 2 (42 CFR Part 2) which prohibit the recipient of these record• from making any further disclosures to third parties without the express written consent of the patient.

I acknowledge that I have been notified of my rights pertaining to the confidentiality of my treatment information/records under 42 CFR Part 2, and I further acknowledge that I understand those rights.

_____
Patient Signature

_____ _____
Parent/Guardian Name (Print) Date

**Appointed Pharmacy**: Name_____

Phone_____ Address_____