



1090 W. State Road 436
Altamonte Springs, FL 32714
407-869-1030

Acknowledgement of Receipt of Privacy Notice

Patient Name: _____ Date of Birth : ____/____/____

Patient Signature : _____ Today date: ____/____/____

Electronic Prescriptions

In order to comply with new government regulations, we will be submitting prescriptions electronically to pharmacies as much as possible. This will be a tremendous benefit to everyone involved. This will not only ensure proper medications and dosages are submitted to the pharmacy, but will also decrease the number of lost prescriptions and medication errors. Any prescription data transmitted will be used only for the express purpose of prescription filling and submissions of the necessary codes to the insurer for payment.

I understand purpose of electronic prescriptions and agree that my prescriptions may be transmitted electronically.

MAIL ORDER PHARMACY NAME: _____ PHONE NUMBER : _____