LIGHTHOUSE PSYCHIATRY

PHARMACY AUTHORIZATION

PATIENT INFORMATION		
Patient Name:	Gender: [ ] Male [ ] Female	DOB:
Home Address:		

I authorize LIGHTHOUSE to have a bidirectional communication with the following:

PHARMACY 1:			
ADDRESS:			
Cross Streets:			
TELEPHONE:		FAX:	
MEDICATIONS:			
SPECIFIC INSTRUCTIONS:			
PHARMACY 2:			
ADDRESS:			
Cross Streets:			
TELEPHONE:		FAX:	
MEDICATIONS:			
SPECIFIC INSTRUCTIONS:			
PHARMACY 3:			
ADDRESS:			
Cross Streets:			
TELEPHONE:		FAX:	
MEDICATIONS:			
SPECIFIC INSTRUCTIONS:			

Patient/Legal Representative Signature   Date   Time

Legal Representative Name   Relationship