List the medications you are applying for through the Patient Medication Assistance Program:


Not every medication can be obtained through a PAP. You will be contacted shortly regarding your request.

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**Patient Consent and Release**

I certify that the information I have provided in this application is accurate and true to the best of my knowledge and belief. I understand that even if my application is approved, services are not guaranteed. I also understand that other documents may be required to provide proof of income.

By signing this application, I authorize representatives of [ORGANIZATION NAME] to ask necessary information of my health care providers to complete applications for medication assistance, and to share this information with pharmaceutical companies as required; and I acknowledge my receipt of [ORGANIZATION NAME]'s Notice of Privacy Practices.

I give permission to the representatives of [ORGANIZATION NAME] to sign patient assistance program applications for me in the event of my absence. This consent to become void in the event I am no longer a patient of [ORGANIZATION NAME].

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**Signature of applicant**

**Date**

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For office use only:

**Date Patient Contacted:**

**# of Medications ordered:**
Signature Consent Letter

One option that you may consider is to have the patient sign a consent letter allowing you to sign applications on their behalf. This practice would save time by eliminating the step of mailing the application to the patient and waiting for them to send it back. It would also save money spent on postage and stationery.

Below is a sample letter that could be used. It should be typed on your letterhead.

Date:

To Whom it May Concern:

I ______________________ give my permission for Coordinator X to sign applications and correspondence on my behalf for the direct benefit of receiving medications as part of the medication assistance program.

Signed ___________________________ Date ___________________________
Physician/Prescriber Referral for Medications

NEW [REDACTED] Patient Only

Phone: [REDACTED] Fax: [REDACTED]

PATIENT CONSENT AND RELEASE FORM

EXCHANGE OF INFORMATION

I give permission to authorized representatives of [REDACTED] to inspect my medical records whenever necessary to obtain pertinent information needed to solicit medications on my behalf from companies that manufacture or provide medications through patient assistance programs. I also authorize [REDACTED] to discuss me and my medical needs with my physician/prescriber when necessary. Additionally, I give [REDACTED] permission to verify my income through the Dept. of Social Services, Social Security Administration, my employer, Veterans Administration or any other company, business, or organization from which I receive income. This authorization is good as long as [REDACTED] is assisting me or until I revoke such.

I agree that a copy of this form can be accepted as a valid consent to share information.

If I do not sign this form, information will not be shared, and I will have to contact each agency, company, or organization individually to give them information about me that they need.

Date Of Birth: ___________________ Social Security Number: ___________________

Address: _______________________

Full Printed Name Of Patient: _________________________________

Signature: _______________________________ Date: ________________

PATIENT SIGNATURE AUTHORIZATION

I authorize representatives of [REDACTED] to sign forms on my behalf for the purpose of soliciting medications on my behalf from companies that manufacture or provide medications through patient assistance programs. This signature authorization is good as long as [REDACTED] is assisting me or until I revoke such.

Full Printed Name Of Patient: _________________________________

Signature: _______________________________ Date: ________________
PATIENT CONSENT AND RELEASE FORM

EXCHANGE OF INFORMATION

I give permission to authorized representatives of the _______ to inspect my medical records whenever necessary to obtain pertinent information needed to solicit medications on my behalf from companies that manufacture and provide medications to the _______. I also authorize _______ to discuss my medical needs and medication requests with my physician/prescriber, and with representatives of _______ when necessary. This authorization is binding for a period of one year from the date this document is signed, and for as long as _______ is assisting me or until I revoke such.

I agree that a copy of this form can be accepted as a valid consent to share information.

If I do not sign this form, information will not be shared, and I will have to contact each agency, company, or organization individually to give them information about me that they need.

Date Of Birth: ___________________ Social Security Number: ___________________

Address: ____________________________

Full Printed Name Of Patient: ____________________________

Signature: ___________________________ Date: ___________________________

PATIENT SIGNATURE AUTHORIZATION

I authorize representatives of the _______ to provide information to representatives of the _______ health care providers, and the pharmaceutical manufacturers for the purpose of soliciting medications on my behalf from companies that manufacture and provide medications to the _______. This signature authorization is binding for a period of one year from the date this document is signed, and for as long as _______ is assisting me or until I revoke such.

Full Printed Name Of Patient: ____________________________

Signature: ___________________________ Date: ___________________________

Please complete and return in the enclosed envelope to: ____________________________
Dear Patient:

Certain pharmaceutical companies offer patient assistance programs to patients without prescription insurance coverage and or cannot afford their medication and qualify under specific guidelines.

Your health care provider has referred you to this department or information from our hospital records show that you may be eligible for one or more of these programs. Our department will handle the majority of the paperwork for you. You may be required to complete an application or answer a few questions by either the company or our department.

While we do our best to locate assistance, we ask that you do your part in supplying the necessary documentation required to complete the applications in a prompt and efficient manner.

Since the majority of the applications require a patient signature, and as it may be difficult to locate you after you have left the clinic, we are offering to sign as your agent and collect the financial data from the patient registration department or classifications with your consent.

(please initial one) I do ___________ I do not ___________

consent to the Pharmacy Program Coordinator signing the program applications as my agent and using the information I provided to the patient registration or classification department in order to apply on my behalf. I understand that assistance for medications applied for will only be for medications that I am currently taking, or have taken within the past 6 months or a medication that my Physician is prescribing at that time.

_________________________   ______________________
Patient Signature                      Date

**There will be no change in the way you currently receive your medications from our pharmacy department. If we do not carry the medication we apply for, we will label it for you specifically or you may be required to have it filled at an outside pharmacy.