Pharmacy Transfer Request Form

Patient information	
Name:	
Address:	City:
State:	Zip code:
Phone number:	Date of birth:
Current pharmacy information	
Name of pharmacy:	
Address:	
Phone number:	
New pharmacy information	
Name of pharmacy:	
Address	
Phone number:	
Medication transfer details	
List of medications to be transferred:	
1.	
2.	
3.	
4.	
5.	
Insurance information	
Insurance provider:	
Policy number:	Group number:
Insured’s name:	Relationship to insured:

Additional notes and instructions

Authorization

I hereby authorize the transfer of my prescriptions and medication records from my current pharmacy to my new pharmacy. I understand that the current pharmacy may require a few business days to process this request and verify my information before completing the transfer.

Patient signature: _____ **Date:** _____

Please allow up to 48 hours for the transfer to be processed. If you have any questions, contact your new pharmacy directly.