



THE MEDICINE CABINET
PATIENT ASSISTANT PROGRAM

Authorization to Release Information

To Whom It May Concern:

1. I have applied for prescription drug assistance from "The Medicine Cabinet". As a part of the application process, "The Medicine Cabinet" and the pharmaceutical manufacturer may verify information in my application and other documents required in connection with the assistance, either before the assistance is granted or as a part of its quality control program.

2. I authorize you to provide to "The Medicine Cabinet" and to any pharmaceutical manufacturer whom "The Medicine Cabinet" appoints any and all information and/or documentation that they request. Such information includes, but is not limited to; employment history, income information including retirement information (i.e. pension, social security benefits, etc.), bank history, money market and similar account balances, and copies of income tax returns.

3. "The Medicine Cabinet" and/or the pharmaceutical manufacturer may address this authorization to any party named in the prescription assistance program.

Temporary Power of Attorney

1. I _____ give "The Medicine Cabinet" and is representative(s) permission to apply for medication assistance programs on my behalf. "The Medicine Cabinet" will have limited Power of Attorney to sign any necessary paperwork, applications and/ or documentations concerning the assistance programs.

2. I understand that I may revoke my authorization at any time by providing a written request of termination of services with "The Medicine Cabinet"

3. A copy of this authorization may be accepted a an original

Member's Name (Print)

Social Security Number

Member's Signature

Date

Name of Personal Representative (If applicable)

Relationship to Member