Vascular Surgical Associates, PC
Patient Pharmacy Form

Patient's name: _____ Date of birth: _____

MEDICAL CONSENT FORM: Pharmacy: _____

Phone # or Street Name: _____

Mail in Pharmacy (if applicable) _____

ID #_____Phone # _____

___ I authorize Vascular Surgical Associates, PC, to obtain information regarding my current prescriptions.

___ I **do not** authorize Vascular Surgical Associates, PC, to obtain information regarding my current prescriptions.

_____ _____
Signature **Date**