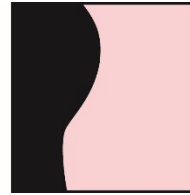


## Pharmacy Information

THE  
WOMAN'S  
HEALTH  
PAVILION



*New York State law requires prescriptions to be electronically submitted to your pharmacy. Please indicate where you would like your prescriptions sent.*

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

Name of local pharmacy: \_\_\_\_\_

Pharmacy address: \_\_\_\_\_

\_\_\_\_\_

Pharmacy phone number: \_\_\_\_\_

*Some insurers require “maintenance medications” (those medication which you will continue to take for months or more) to be processed through a “mail-away” pharmacy instead. Please indicate how we should process your maintenance medications:*

Your mail-away ID # \_\_\_\_\_

Mail-away pharmacy name: \_\_\_\_\_

Mail-away pharmacy address: \_\_\_\_\_

\_\_\_\_\_

Mail-away pharmacy phone # \_\_\_\_\_

Mail-away pharmacy fax # \_\_\_\_\_

***\*\*Please provide us with a copy of your pharmacy ID card\*\****

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date Signed