Pharmacy Prescription Transfer Template

PRIVACY ACT STATEMENT

In accordance with the Privacy Act of 1974 (Public Law 93-579), this informs you of this document's purpose and how it will be used.
AUTHORITY: 10 U.S.C 136; 10 U.S.C. 1074f; DoD Directives 1404.10, 5101.1, 5136.01, and 6490.02E; and DoD Instruction 6025.19. **PURPOSE:** To obtain information in order to transfer prescriptions to the Military Treatment Facility at the beneficiary's request. **DISCLOSURE:** Voluntary.

SECTION A: COMPLETED BY (SELECT ONE)*

☐ **Patient** ☐ **Patient's Legal Guardian** _____

DATE*:	

Fields marked with an asterisk (*) are required. Please include as much information as possible. When finished, hand, fax, or electronically submit this authorization to your pharmacy to begin the process. If you have bottles, packages, or labels from the prescriptions you would like transferred, providing them to your pharmacy may expedite the processing of your request.

PATIENT INFORMATION

NAME (Last, First, MI)*:	DOB (MM/DD/YYYY)*:	DOD ID# or Sponsors Last 4
Phone #*:	Address (Street, City, State, and ZIP Code):	
Allergies *(please list all allergies)*:		

TRANSFERRING FROM INFORMATION

Pharmacy Name*:	Pharmacy Phone #*: *(Check Rx label)*
Address (Street, City, State, Zip Code):	Fax:

PRESCRIPTION INFORMATION (List all of the medications you would like transferred; additional medications on reverse side)

Medication Name(s)*:	Prescription #(s):
1.	1.
2.	2.
3.	3.

SUBMIT

ADDITIONAL PRESCRIPTION INFORMATION (If necessary)	
Medication Name(s)*:	Prescription #(s):
4.	4.
5.	5.
6.	6.

SUBMIT