CANADA PRESCRIPTION SERVICE Nevada

MEDICAL INFORMATION/AUTHORIZATION AND RELEASE FORM (FOR NEW CLIENTS ONLY)

Client Name: _____ Gender _____

Phone (_____) _____ Date of Birth _____

Known Drug Allergies: _____

_____

Current Medications (List all): _____

_____

_____

Please summarize your medical condition: _____

_____

_____

_____

_____

A duly qualified physician in my jurisdiction prescribed the pharmaceuticals ordered by me for myself. The duty of care is the responsibility of my physician who originally prescribed the ordered pharmaceuticals. I release and discharge Canada Prescription Service from any and all causes of action with respect to any late delivery of pharmaceuticals sent to me. I undertake and acknowledge that pharmaceutical products may not be returned for refund or exchange. I understand that it is my responsibility to have my medical condition and medications obtained in Canada monitored by my American doctor in the USA. I release and discharge the Canadian co-signing physician from any and all liability arising from the use of the ordered pharmaceuticals. By signing this waiver, I agree to release liability and hold blameless Canada Prescription Service including all of their affiliates, directors, officers, employees, agents, physicians, and pharmacists from all causes of action, suits, penalties, liens, judgments, liabilities, obligations, losses, actual or consequential damages, actual or threatened claims which may arise at any time by reason of relating to, arising directly or indirectly out of any matter whatsoever related to the prescribing or dispensing of my prescription medications and the use and disclosure of my health information in connection with these services. I understand that Canada Prescription Service may not be directly subject to state or federal privacy laws. I permit Canada Prescription Service to use and disclose my health information to provide services to me and to operate its business. I understand that Canada Prescription Service will take commercially reasonable steps to maintain the confidentiality of my health information. I acknowledge that the physicians and pharmacists contracted by Canada Prescription Service are located and licensed to practice medicine and pharmacy in Canada.

_____ _____

Signature Date Witness Signature Date