

**Medication Therapy
Management**

Kemper Drug
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Consent for Release of Medical Information

Medication Therapy Management is a comprehensive review of your medications and medical conditions designed to identify and resolve potential problems in order to obtain favorable medication outcomes.

I understand that my pharmacist may need to discuss my care with my physician and other health care providers. I understand that the pharmacist may need to discuss my care with my insurance company if required to obtain reimbursement. I do hereby grant permission for Kemper Drug to request medical/health information from other members of my health care team. This information will be shared with my pharmacy confidentially and specifically for my care.

By signing my name below, I acknowledge receiving a copy of this document and agree to the sharing of my health information between the pharmacy and other members of my health care team. I understand that I may revoke this consent at any time by providing written notice to Kemper Drug. I also understand that any release of medical information prior to my revocation shall not constitute a breach of my rights to confidentiality.

Date _____

Patient Name: _____ DOB _____

Address _____

City, State, Zip Code _____

Patient / Caregiver Signature _____

Relationship of Caregiver to Patient _____

Pharmacy Representative _____