Grace Health & Wellness Clinic
1601 Main Street
STE 404
Richmond, TX 77469
Phone: (346) 444-3653 / Fax: (855) 576-4465

Preferred Pharmacy Form

(Confidential – For Clinic Use Only)

I. PATIENT INFORMATION

Full Legal Name: _____

Date of Birth (MM/DD/YYYY): _____ Age: _____

Phone Number: _____

☐ Home ☐ Mobile ☐ Work

Email Address: _____

II. PREFERRED PHARMACY INFORMATION

Preferred Pharmacy Name: _____

Pharmacy Address: _____

City: _____ State: _____ Zip Code: _____

Pharmacy Phone Number: _____

Pharmacy Fax Number (if known): _____

Pharmacy Type (check one):
☐ Retail Pharmacy (e.g., CVS, Walgreens, Walmart, etc.)
☐ Independent/Local Pharmacy
☐ Mail-Order Pharmacy
☐ Specialty Pharmacy

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III. SECONDARY OR BACKUP PHARMACY (OPTIONAL)

Secondary Pharmacy Name: _____

Pharmacy Address: _____

City: _____ State: _____ Zip Code: _____

Pharmacy Phone Number: _____

Pharmacy Fax Number (if known): _____

Pharmacy Type (check one):
☐ Retail Pharmacy (e.g., CVS, Walgreens, Walmart, etc.)
☐ Independent/Local Pharmacy
☐ Mail-Order Pharmacy
☐ Specialty Pharmacy

IV. CONSENT & AUTHORIZATION

I authorize **Grace Health & Wellness Clinic** to send electronic or faxed prescriptions to my preferred pharmacy. I understand that it is my responsibility to inform the clinic if my preferred pharmacy changes.

_____ _____
Signature of Patient or Patient's Representative Date

_____ _____
Printed Name Representative's Relationship to Patient