MyDoseAlert™
The right medication at the right time.

Patient Enrollment Form

☐ **New Enrollment** ☐ **Update Reminder**

Name _____ Birthday Date_____

Email Address(s) _____

Street Address _____City_____ State_____ ZIP_____

Home Phone Number _____Cell Phone Number _____

What type of alerts would you like to receive? ☐ Take Medication ☐ Refill Prescription ☐ Other Reminders

Send my reminders via (check all that apply) ☐ Home Phone Call ☐ Cell Phone Call ☐ Text Message ☐ E-mail

If the need should arise, do we have your permission to contact you by any of the above methods with timely and relevant health information? ☐ Yes ☐ No

Prescription Medication	**Frequency –** How often and at what time(s) do you need a reminder?
_____	_____
_____	_____
_____	_____
_____	_____

OTC Medication (Aspirin, Allergy, etc)	**Frequency –** How often and at what time(s) do you need a reminder?
_____	_____
_____	_____
_____	_____
_____	_____

Vitamins and Supplements	**Frequency –** How often and at what time(s) do you need a reminder?
_____	_____
_____	_____
_____	_____
_____	_____

Other Reminders (Blood sugar readings, blood pressure, flu shots, etc.)	**Frequency –** How often and at what time(s) do you need a reminder?
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

By my signature on the back of this form, I attest the information above is true and correct. I also understand that if there is any change in the way I take my medication, it is my responsibility to contact the Pharmacy at: 615-824-2179. I acknowledge that I have received and agree to the My Dose Alert Terms and Conditions of Use. If I have indicated that I would like to receive alerts via telephone, I acknowledge that I would like to receive telephone calls that deliver prerecorded messages at the telephone number(s) I provided. Finally, I acknowledge that text messaging and airtime charges may apply depending on my phone provider contract.

(OVER)

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Health Mart ("Pharmacy"), PHARMACY DEVELOPMENT SERVICES, INC. ("PDS"), AND INTELECARE COMPLIANCE SOLUTIONS, INC. ("INTELECARE" AND, TOGETHER WITH PHARMACY AND PDS, COLLECTIVELY, THE "PROVIDERS") WILL NOT SHARE YOUR PERSONALLY IDENTIFIABLE INFORMATION WITH ANY THIRD PARTY WITHOUT YOUR CONSENT UNLESS REQUIRED BY LAW OR WHEN NECESSARY TO PROTECT OUR RIGHTS AND/OR TO COMPLY WITH A JUDICIAL PROCEEDING, COURT ORDER OR LEGAL PROCESS SERVED ON US. PHARMACY, PDS AND/OR INTELECARE MAY, FROM TIME TO TIME, CALL OR SEND YOU INFORMATION THAT MAY BE OF INTEREST TO YOU BASED ON YOUR HEALTH PROFILE AND ACTIVE REMINDERS. YOU CAN OPT-OUT OF RECEIVING THESE COMMUNICATIONS AT ANY TIME.

Authorization. This is an authorization by _____ (the "Patient") for use and disclosure of the Patient's health information created or received by any of the Providers.

Information That May Be Disclosed. Information that may be disclosed or used by any of the Providers under this authorization includes information regarding the Patient's medications, health tests, or other reminders designated by Patient on the My Dose Alert Patient Enrollment Form.

People Who May Disclose. The people who may use or disclose the Patient's medical information pursuant to this authorization are any employee or other representative of any of the Providers. Patient acknowledges that the Providers will store Patient's information on the My Dose Alert System of PDS' Marketing Solution Center, an interface of Intelecare's Intelecare Solutions.

People Who May Receive. The people who may receive the Patient's information are the Patient and any third person who has access to the Patient's personal property (i.e., the Patient's telephone, computer, etc.) through which the Providers will provide alerts to the Patient through My Dose Alert. Patient acknowledges that Patient has sole control and responsibility over determining which, if any, third persons have access to the personal property on which Patient will receive alerts from the Providers. Therefore, Patient authorizes the Providers to release Patient's information to any such third persons.

Purposes. Information disclosed or used under this authorization may be used for the purposes of alerting the Patient through The Marketing Solution Center and My Dose Alert of the time that the Patient should take his or her medication or any other health-related reminders. The Providers will alert the Patient through the My Dose Alert System via the mode of communication requested by the Patient, including, but not limited to, telephone calls, text messages, or electronic mail.

Redisclosure. Information disclosed under this authorization will be given to recipients who may redisclose the information and those later disclosures may not be protected by law.

Expiration and Revocation. This authorization will continue in effect until the earlier of the death of the Patient or the revocation of this authorization by the Patient or by a legal or authorized representative of the Patient. The Patient may revoke this authorization in writing at any time, except to the extent that the Providers have acted in reliance on this authorization. Revocation may be made in writing delivered to the Pharmacy at the following address247 West Main Street, Hendersonville, TN 37075.

Notification of Breach of Patient's Information. In the event that any unsecured personal health information of Patient, as defined by 42 U.S.C § 17932(h)(1), is breached, or is reasonably believed by the Providers to have been breached, the Providers will notify the Patient as required by applicable law.

Patient Access and Refusal. The Patient may inspect or copy the information disclosed under this authorization by delivering a written request to the Pharmacy at the address listed above. The Patient may refuse to sign this authorization.

By signing below, the Patient authorizes the Providers to use and disclose information as described in this authorization.

_____ _____

Patient's Signature Date

_____

Patient's Name (Please Print)