



321 Main Street Ste. B Winooski, VT 05404  
802-655-3544 or 1-800-638-1675 Fax 802-655-0123  
www.freedompharmacyvt.com

MEDICAL RECORDS RELEASE

Patient's Name: \_\_\_\_\_ Patient's DOB: \_\_\_\_\_

I authorize Freedom Pharmacy to release medical and billing information to the following (other than self or physician offices): LIST ALL

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

GUARANTEE OF PAYMENT

This is to certify that we, Freedom Pharmacy, will receive reimbursement from the guarantor listed below for prescription medications, over-the-counter products, co-pays, administration fees and any non-covered medications/products/services for the patient listed above for products/services rendered.

SEND BILLS TO PATIENT

SEND BILLS TO GUARANTOR LISTED BELOW

Name of Guarantor: \_\_\_\_\_

Address of Guarantor: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Guarantor Signature: \_\_\_\_\_ Date \_\_\_\_\_

**Regardless of whether or not the patient has prescription insurance benefits, the patient and/or guarantor (payee) will need to make payment arrangements in advance with our billing department in the form of a credit card or checking/savings account in order for services to start (see attached automatic payment form)**

Patient Signature: \_\_\_\_\_ Date \_\_\_\_\_