I choose

as my pharmacy.

Please release any information that they ask for, including any Prior Approval authorization.

Patient Information – Required:

Name:

Birthday:

Community:

PHIN or Treaty Number:

PO Box #:

Phone:

CONSENT TO ACCESS HEALTH INFORMATION AND TRANSFER PHARMACY CARE

I agree to transfer my health information to IcMD LifeSmart Pharmacy for the provision of pharmacy care. I agree to having IcMD LifeSmart Pharmacy transfer my medications from my current pharmacy in order to provide collaborative medical care with the medical teams and nursing stations. I agree to allow for IcMD LifeSmart to collaborate with my communities' medical trustees for the provision of healthcare services. All discussions will abide by the Personal Health Information Act.
I sign this after being fully informed about the service offering.

Signature: _____

Date: _____

Please fax completed forms to IcMD LifeSmart Pharmacy: 204-832-4263
or by email to lifesmarticmd@gmail.com