# Prescription History Request Form

Instructions: To request a copy of your prescription history, please complete the information below, sign in the space provided and return to Eagle Pharmacy, 350 Eagles Landing Drive, Lakeland, Florida 33810 or via fax at (877) 283-9171.

## SECTION A: PATIENT INFORMATION

**Name:** _____ **Date of Birth:** ____ / ____ / ____

**Address:** _____

**City:** _____ **State:** _____ **ZIP:** _____

## SECTION B: PRESCRIPTION HISTORY DATES

**Prescription History Time Period:** From: _____ / ____ / ____ To: _____ / _____ / ___

## SECTION C: PRESCRIPTION HISTORY ACKNOWLEDGEMENT

I am requesting a copy of my prescription history for the time period indicated above. I authorize Eagle Pharmacy to mail my prescription history to the following address:

**Address:** _____

**City:** _____ **State:** _____ **ZIP:** _____

I understand that sensitive information such as: mental health, HIV/AIDS and alcohol/drug abuse may be included in the prescription history, if such information is on file at Eagle Pharmacy.

**If the individual signing this form is not the patient, the individual must sign and attach documentation showing authorization to act on behalf of the patient.

**Patient Signature:** _____ **Date:** _____

**Print Name:** _____