

MEDICATION ORDER FORM

Canada Drugs
8397 Northcliffe Blvd.
Spring Hill, Fl. 34606
P:352-683-4446 F:352-683-4337

Date: _____

(Prescriptions for each product ordered must accompany this form)

Patient Name: _____ Date of Birth: _____

Mailing Address: _____ Apt/Space: _____

City: _____ State: _____ Zip Code _____

Home Phone: () _____ Other Phone: () _____

Height _____ Weight _____

Requested Medication (Indicate Brand or Generic For Each)	Dosage / Description	Quantity	Price U.S. Dollars

**Plus Shipping and Handling: \$13.00 Canada Per Shipment
\$4.50 U.S/ Per Shipment**

Name of Person Who's Order Is To Be Shipped With This Order (If Applicable)

I hereby waive my right to pharmacy counseling, as I have been previously counseled regarding the above mentioned.

Please do not contact me regarding this order, but rather ship the medication as described above.

I have read and / or received the Notice of Privacy Practices Statement from the Pharmacy (HIPPA).

Payment Method - Mastercard Visa Discover Certified / Bank Check

Name on Card: _____

Credit Card # _____ **CVV2** _____ **Exp:** _____

Signature: _____ **Date:** _____

Credit Card Billing Address If Other Than Ship To Address (Required):

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