



# THE UNIVERSITY OF SOUTHERN MISSISSIPPI.

MOFFITT HEALTH CENTER

118 College Drive #5066 | Hattiesburg, MS 39406-0001

Phone: 601.266.5340 | Fax: 601.266.4205 | [www.usm.edu/health-center](http://www.usm.edu/health-center)

## Prescription Delivery Request & Consent

Moffitt Health Center Pharmacy

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

University ID Number: \_\_\_\_\_

Delivery Location (Campus Building & Room Number): \_\_\_\_\_

Cell Phone Number: ( ) \_\_\_\_\_

Designated Person to Accept Delivery If You Are Not Available: \_\_\_\_\_

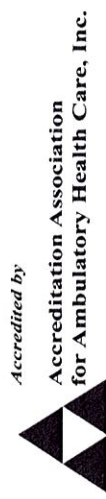
*By signing below, I am providing my consent to have the above prescription(s) delivered to the location provided by me. Further, I understand the following:*

- 1. I agree to allow this prescription(s) to be delivered to the designated campus location to the patient or a designated accepting person who will sign for the receipt of the medication.*
- 2. I agree to this prescription(s) being delivered by a pharmacy courier who has been HIPAA trained in a white bag marked only by the patient's name and address.*
- 3. I agree that it is my responsibility to inform the Moffitt Health Center Pharmacy if and when I should need to change or cancel the delivery of my prescription(s).*
- 4. I agree to allow the Moffitt Health Center Pharmacy to send me SMS/text messages via my personal cell phone for notifications relating to my prescription delivery.*
- 5. I agree to allow the Moffitt Health Center Pharmacy to charge all balances relating to the delivered prescription(s) to my credit card prior to delivery via phone OR at the time of delivery via mobile credit card terminal.*

*I have read and understand the above risks and requirements and do hereby grant my consent for the Moffitt Health Center Pharmacy to deliver my prescription(s) to the location provided above.*

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

*Please feel free to hand deliver this form to our Pharmacy.*



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