

If you have a local pharmacy that you regularly use and would like it to be entered into your record, please complete the information below.

Patient Name: _____

Patient Date of Birth: _____

Pharmacy Name: _____

Pharmacy Phone Number: _____

Address: _____

As part of our innovative customer service, we regularly update/educate you at Parker, Schlichter & Associates, and Corepsych

For the *latest, easy to read news* in child and adult mental health care, meds, other medical conditions and brain science. We will sign you up for email updates if you give us your email address.

Print Name: _____

Email: _____

You will be notified by email and *need to authorize our server* to send it. We will sign you up, and won't share your address with anyone.