WISCONSIN PHARMACY QUALITYCOLLABORATIVE
an initiative of the pharmacy society of wisconsin

Comprehensive Medication Review and Assessment Consent Form

Check the box indicating who is authorizing the CMR/A
□ Patient (Complete section I)
□ Caregiver (Complete section II)
□ Pharmacy staff representative on behalf of patient for telehealth visit (Complete section I)

I. I hereby authorize _____ Pharmacy to review my medications. I understand that any changes to my medications will not be made without the permission of my physician(s).

I understand that every effort will be made to maintain the confidential nature of my personal health information.

Signature of Patient: _____ Date: _____

Print Patient Name: _____

II. I _____ (caregiver name), hereby authorize _____ Pharmacy to review the medications of _____ (patient name). I understand that any changes to my medications will not be made without the permission of the physician(s).

I understand that every effort will be made to maintain the confidential nature of this personal health information.

Print Patient Name: _____

Signature of Caregiver: _____ Date: _____

Print Caregiver Name: _____