New form: ___ Renewal: ___ Written Consent Expiration Date (1 year from consent date) _____

UC DAVIS HEALTH | Pharmacy

Pharmacy Administration
UC Davis Medical Center
Sacramento, CA 95817

Automatic Refill Program Enrollment Form

I hereby authorize **UC Davis Health Pharmacy** (Pharmacy) to automatically refill prescription(s) listed on this form.

It is my responsibility to notify Pharmacy of any changes in mailing address, drug, dose, or refill schedule to prevent any unnecessary fills.

It is my responsibility to contact Pharmacy by phone if I wish to discontinue automatic refills entirely or only a single medication. Prescriptions may not be returned once they have left the pharmacy.

Automatic refill enrollment will expire after 1 year and a new form will be required to renew enrollment.

Please retain a copy of this notice for your records.

Print Name:	Medical Record Number #
Address:	Phone Number:
Medications for Automatic Refill: 1. 2. 3. 4. 5.	Medications for Automatic Refill (continued): 6. 7. 8. 9. 10.

Name _____ Relationship to Patient _____

Signature _____ Date _____

Please present this completed consent form to your preferred UCDH Pharmacy:

FOR PHARMACY USE ONLY: Initials _____ Date Received _____

Scan into Epic WAM Documents: Automatic Refill Program-Enrolled
List each prescription into Description

Updated 09/21/2021