ALISTER A. GEORGE, M.D.
GASTROENTEROLOGY & HEPATOLOGY
Board Certified in Gastroenterology

PHARMACY DESIGNATION FORM

Please be aware we will only send your prescription to one local pharmacy and, if you have one, one mail order pharmacy. If you need a refill, contact your pharmacy and they will send us the request to be refilled. Allow 48-72 business hours for the refill to be completed. Please note that there are certain prescriptions we cannot refill early; however, if you are running low, please contact the pharmacy within the 48-72 hour period before you run out so that we may refill your prescription in time.

Please provide the information for your preferred pharmacy below, including street address, street name and/or cross street, and city, if known.

Sincerely,

Alister A. George, M.D.

Patient Name:_____ Date of Birth_____

Pharmacy Name_____ Phone Number:_____

Street Address (or cross streets) & City:_____

_____

Signature: _____ Print Name: _____Date:_____
(Signature of the Patient or Responsible party)

If you change your preferred pharmacy, you must notify Alister A. George, M.D. and complete a new Pharmacy Designation Form. Forms can be requested at check-in.