Please complete both pages for **each** family member receiving deliveries from this pharmacy. Each patient 18 years and over must sign his/her own. If under 18, parent/guardian can sign.

Creighton University Campus Pharmacy

Delivery Authorization and Waiver

The patient/insured whose prescriptions may be delivered is:

NAME_____ **D.O.B.**_____

I authorize Creighton University Campus Pharmacy (the Pharmacy) to deliver my prescriptions, including refills, to the above-listed Creighton University (CU) worksite address. I further authorize the Pharmacy to leave my prescriptions with CU staff in the department/work area.

I understand that:

- I will be required to arrange for payment of all co-payments/medication expense prior to delivery of my prescriptions. Payment may be made via credit card, debit card, or FSA/HSA Card. **My prescriptions will remain at the Pharmacy for pick-up if payment is not received prior to the time of delivery.**
- My prescriptions will be packaged and will not externally identify the contents as containing prescription medications or my health information.
- Packages shall be marked **" CONFIDENTIAL".**
- The Pharmacy will only deliver prescriptions to the worksite address above during normal working hours, Monday through Friday, 8:30 a.m. to 4:30 p.m., excluding University holidays.
- If my prescription is ordered on a weekday **other than Friday**, I will allow 24-48 hours from the time the request is received in the Pharmacy for delivery of routine prescriptions; I understand special order items, transfers from other pharmacies, prescriptions ordered on Friday or a weekend, or prescriptions with no refills remaining will take additional time to be delivered.
- I release, waive, discharge and covenant not to sue CU or the Pharmacy from and for any liability, claims, demands, actions or causes of action whatsoever arising out of any loss, damage or injury that may be sustained by me or my property as a result of the delivery of my prescriptions including, but not limited to, theft or loss of my prescriptions by any third party (including CU staff) or breach of privacy if CU staff open and/or review the contents of packages from the Pharmacy.
- It is my duty to notify the Pharmacy in writing as soon as possible of any changes in my work status (or that of the employee named above) at CU, including relocation of office/work area or termination of employment at CU.
- I may revoke this authorization and waiver at any time by written notice to the Pharmacy.
- This authorization and waiver terminate when the worksite address specified above changes. To renew it, I must complete new forms and submit to the Pharmacy.

I **ACKNOWLEDGE RECEIPT OF Creighton University's Notice of Privacy Practices.**

Patient's Signature_____**Date**_____