AUTHORIZATION TO SPEAK ON MY BEHALF

I hereby authorize the following individual to speak on my behalf regarding my prescription services, refills, renewal, pick-up or delivery.

_____	_____
Name	Relationship
_____	_____
Name	Relationship

AUTHORIZATION TO LEAVE MESSAGES

I hereby authorize that phone messages and/or text messages are allowed to be left at the below numbers regarding my prescription services, refills, renewal, pick-up or delivery. I understand that phone messages are not secure means of communication and that there is some risk that any Protect Health Information contained in such a message could be disclosed to unauthorize third parties.

CHILD-RESISTANT PACKAGING

I understand that some products and medications are not available in child-resistant package. I accept full responsibility for the use of all medications and understand that IV RX cannot be held liable for the misuse or accidental use of any medications regardless of packaging.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of IV RX's Notice of Privacy Practices ("Notice"). It can also be obtained via IV RX website: www.ivrxpharmaceuticals.com. It can also be requested via telephone, email, fax or in person at the IV RX location.

PATIENT BILL OF RIGHTS

I acknowledge that I have received a copy of IV RX Patient Bill of Rights and that I understand my rights contained therein. It can also be obtained via IV RX website: www.ivrxpharmaceuticals.com. It can also be requested via telephone, email, fax or in person at the IV RX location. Further, I acknowledge that Ica n contact IV RX should I have questions about the Bill of Rights or should I not clearly understand them.

PATIENT BILL OF RIGHTS

I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment from IV RX. However, if I choose not to sign, I will not receive communication about, nor will I be enrolled in, the patient assistance program described above.

I further understand that, if I elect not to sign tis Agreement, I am still subject to certain provisions contained within it as Terms of Services for obtaining products or services from IV RX. Terms of Services include the sections entitled Financial Responsibility, Release of Information, Child-Resistant Packaging and Patient Bill of Rights.

By signing below, I certify that I have read and accepted the terms of this Patient Agreement and that I received a copy. I also certify that I am the patient, or that I am duly authorized by the patient as the patient's agent to accept and sign this Patient Agreement on behalf of the patient.

_____	_____
NAME OF THE PATIENT OR AUTHORIZED REPRESENTATIVE	SIGNATURE