

Global Rx Store~Authorization & Release Form

MY PERSONAL INFORMATION

First Name: _____ Last Name: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____
 Phone: _____ Fax: _____ Sex: _____
 Date of Birth: _____ (mm/dd/yy) Weight (lbs): _____
 Secondary Contact: _____
 Phone: _____ Relationship: _____

MY PRIMARY PHYSICIAN

Doctor's Name: _____ Phone: _____
 Address: _____ City/Town: _____
 State: _____ Zip Code: _____ Fax: _____

MY CURRENT MEDICATIONS

These are the medications that have been prescribed to me to treat the following conditions:

Medication	How long	Condition (if known)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

The undersigned, (Hereafter the "Client") confirms that:

1. The Client is of the age of majority in the jurisdiction in which the client ordinarily resides (Place of Residence").The Client is not restricted from making his or her own medical decisions under the laws of the Place of Residence of the Client.
2. The Client confirms to Global Rx Store.com./Licensed Canadian Pharmacies/Licensed Canadian Staff/Licensed Canadian Doctors/USA Sales Affiliates, (hereinafter "The Providers") that the pharmaceutical(s) ordered by the Client ("the Ordered Product") were prescribed by a duly qualified medical practitioner in the Place of Residence of the Client. The Client has not violated any laws in the place of Residence of the Client in obtaining the prescription for the Ordered Product.
3. The Client confirms that the Ordered Product will not be used in any way whatsoever, except as prescribed by the duly qualified medical practitioner who issued the Prescription to the Client ("The Client's Doctor"). The Client confirms that no person other than the Client will use the ordered product.
4. The Client attorns to the jurisdiction of Manitoba and agrees that the laws of the Province of Manitoba and the Federal Government of Canada, as applicable, shall govern any dispute that arises between the Client and the Providers. The Client further agrees that if any dispute shall arise between the Parties pursuant to this Agreement as to the rights or liabilities of the parties to this Agreement, then every such dispute shall be referred to a single arbitrator if the parties cannot agree upon one. Otherwise, upon motion of either party to any Judge of the Court of Queen's Bench for Manitoba, such judge shall be entitled to name a single Arbitrator, whose appointment shall be final and binding upon the parties. In all respects, subject to the terms of this agreement. The Arbitration Act of Manitoba and amendments thereto shall govern such proceedings and the arbitrator shall be entitled to fix and apportion liability for the costs of the arbitration. The award or determination, which shall be made by the said arbitrator, shall be absolutely final and binding upon the parties. The Client acknowledges that the Ordered Product may not be returned for a refund or exchange.
5. Any patient receiving a prescription from a pharmacy in Manitoba has the right to receive counseling in a private and confidential manner from a licensed pharmacist. This counseling includes:

a. The drug name	e. What to do if a dose is missed
b. What the drug does	f. Food, drink, other drugs or activities to avoid
c. How and at what time the drug should be taken	g. Special storage requirements
d. The importance of taking the drug as directed, regularly or as needed	h. Refill information

Would you like a Pharmacist to contact you? ___ YES ___ NO

When would it be convenient for a pharmacist to contact you? _____

If you wish to be counseled please state the best time you can be contacted. _____

Per _____ Date _____

MY PERSONAL MEDICAL HISTORY (Submitted only with your FIRST ORDER)

* I have been diagnosed or treated for the following conditions:

	No	Yes	Description
Drug Allergies			
Medical Condition			
Cancer			
Immune Disorders			
Poor wound healing			
Neurological disorders			
Diabetes, thyroid or other endocrine disorders			
Known nutrition deficiency including minerals or electrolytes			
Lipid or cholesterol disorder			
Heart disease including arteriosclerosis, angina, heart failure or history or heart attack			
Renal or kidney disease			
Liver disease			
Blood Disorders			
Orthopedic or muscle disorder, including fracture, joint disorder or carpal tunnel syndrome			
Emotional disorders			
Surgery			
Glaucoma			
Hyperlipidemia (high cholesterol)			
Chemical dependency			
Upper respiratory disorders			
Smoker			
Lung disorder (i.e. asthma, emphysema)			
Rheumatoid arthritis, lupus, or connective tissue diseases			
High blood pressure			
Other illness not listed above			

BY SIGNING THIS DOCUMENT THE CLIENT CONFIRMS THAT HE/SHE HAS READ AND UNDERSTOOD THESE TERMS AND THAT THEY ARE TRUE AND CORRECT AND THE CLIENT AGREES THAT THE TERMS HEREIN ARE BINDING ON THE CLIENT AND THE HEIRS ASSIGNS, SUCCESSORS AND PERSONAL REPRESENTATIVES OF THE CLIENT. (Submit with FIRST ORDER)

Signature _____ Date _____

Prescription Order Form & Doctor's Prescriptions must accompany this Form. by TOLL FREE FAX: 1-866-371-6853 or by

RETURN Postal Mail to: Global Rx Store 202 – 2727 PORTAGE Ave. Winnipeg, MB R3J OR2 Canada

REMEMBER THAT WHEN MAILING TO CANADA FROM THE USA – 60 CENTS POSTAGE IS REQUIRED