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I ________________________________, born on ___/___/_______,

have been prescribed by my "Health Care Providers" the medicine(s) ______

____________________________,____________________________,

____________________________.

I am requesting the medication:

1. Be changed to [ ] a less costly generic alternative, if available.
2. Be changed to [ ] the medicine my insurance health plan has authorized.

I am aware that co-payment can vary greatly based on my insurance company formulary. I understand the alternative option recommended by my health insurance plan may not adequately control my illness or problem. I am aware of the risks and benefits of any change not authorized by my physician.

I am releasing the above "Health Care Providers" from any liability that may arise from my request to change to the medicine my health plan wants me to take.

We as your primary care physicians will make this change only if agreed upon by you. I understand that the person deciding what medicine I need to take, may be the health insurance plan and not my physician.

____________________________ ________________

Patient's Signature Date

____________________________ ________________

Doctor's Signature Date