



NORTHERN
NEW ENGLAND
BenefitTrust

Teamsters Rx Pharmacy

**Teamsters
Rx**

IMPORTANT NOTICE

Authorization To Release Prescription Information/Records

I hereby authorize Teamsters Rx Pharmacy to release any and all of my own prescription information to be sent to me for my own personal information.

Member's Name

Member's Social Security Number

Member's Address

Member's Signature

Date

Received By Teamsters Rx Pharmacy (Initial)

Purpose That Information Is Required (i.e., tax purposes, personal information, etc.)
