Community Health Rx of Torrington
Prescription Transfer Request Form

As a Community Health Center of Torrington patient, you have access to our onsite pharmacy. Our pharmacy has greater access to your health care providers and medical information allowing them to provide you a faster and higher level of care to meet your unique clinical needs.

Patient Information

Last Name:_____ First Name: _____ Middle Initial :___

Address_____

City: _____ State_____ Zip:_____

Gender: M/F Date of Birth :_____

Current Pharmacy Information

Pharmacy Name:_____

Pharmacy Phone:_____ City: _____ State_____

Allergies to Medications:

_____

_____

I authorize Community Health Rx to contact my current pharmacy provider and begin the process to have my prescriptions transferred.

Patient/Personal Representative Signature: _____

Date: _____

If possible, please supply a copy of your Pharmacy insurance card as well