Fax Consent Form

Pharmacy Customer Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Pharmacy Fax Number: _____

I hereby

☐ authorize

☐ do not authorize

Second Source Rx (or the "company") to send faxes to the pharmacy fax number listed above information regarding the company, specials, promotions, or any advertisement that provides sales and savings opportunities. I confirm that I am authorized to opt-in the pharmacy customer for the specific fax number listed above.

Name: _____

Signature: _____ Date: _____

Please return completed form via email to your Second Source Rx Sales Representative or fax to 1-855-559-5636.