Patient Release Form

To be completed by the patient - required for first order only

I, the undersigned, (hereinafter the “Patient”) confirm that

1. The Patient is of the age of majority in the jurisdiction of which the Patient ordinarily resides:

   (Place of residence) _____

2. The Patient is not restricted from making his or her own medical decisions under the laws of the Place of Residence of the Patient.

3. The Patient fully understands that it would be a violation of the law to falsify information on their medical questionnaire for the purpose of obtaining prescription medication. The Patient agrees to truthfully and to the best of their knowledge answer all questions on their medical questionnaire.

4. The Patient confirms that thriftymedsnow.com and Ellis Pharmacy (hereinafter “The Providers”) that the pharmaceutical(s) ordered by the Patient (“the Requested Medications”) were prescribed by a duly qualified medical practitioner in the place of residence of the Patient.
   The Patient has not violated any laws in the Place of Residence of the Patient, in obtaining the prescription for the Requested Medications.

5. The Patient confirms that the Requested Medications will not be used in any way whatsoever, except as prescribed by the duly qualified medical practitioner who originally issued the Prescription to the Patient (“the Patient’s Doctor”) and that duty of care is the responsibility of the Patient’s Doctor.

6. The Patient confirms that no person other than the Patient will use the Requested Medications.

7. The Patient grants Limited Power of Attorney to the Providers, for the limited purpose of signing any documents as required by the laws of the Province of Manitoba (Canada), which are necessary to permit the delivery of the Requested Medications to the Patient, in the same manner as the Patient could, if the Patient had personally attended the Providers place of business in Manitou, Manitoba, Canada.

8. The Patient attorns to the jurisdiction of Manitoba and agrees that any dispute that arises between the Patient and the Providers shall be heard by the courts in Manitoba, Canada.

9. The Patient acknowledges that the Requested Medications may not be returned for a refund or an exchange.

Signature: _____ Date: _____

Print Name: _____