Medical Information Request Form

Contact Information of Requesting Healthcare Professional	
Name of Requesting Healthcare Professional	Institution Name/Practice Name:
Type of HCP: ☐MD ☐OD ☐DO ☐Ph.D ☐R.Ph ☐R.N ☐PharmD ☐ Other: _____	City, State, ZIP:
Telephone Number (with area code):	Preferred Method of Response: ☐ ☐Email ☐Phone ☐MSL Visit Requested
Best time to contact (if phone):	
Email:	

Medical Inquiry	
Request Not Valid Without Healthcare Professional's Acknowledgement Below: *By clicking the acknowledgement, I hereby confirm that the medical information requested was at my initiation, as a healthcare provider, and not solicited in any manner by an ImprimisRx/Harrow representative. I also certify that the information provided will not be shared with other parties. The wording above accurately reflects the medical information I hereby request to be provided to me by ImprimisRx/Harrow.*	
Healthcare Professional's Signature	**Date**
X	