Release and waiver

ardon

I, _____, acknowledge that I have ordered certain specialty medications from Ardon Health ("Ardon"), and that such medications will be delivered to me at my residence or other address designated by me. I understand that Ardon typically delivers specialty medications to individuals through a process that requires a signature upon delivery to confirm receipt. I hereby instruct Ardon to arrange for such specialty medications to be delivered in a manner that the signature of the recipient is not required.

I understand that by releasing the signature requirement upon delivery, such medications will be left at my residence or designated address, and there is a possibility that such medications may be stolen or damaged. By signing this release and waiver, I acknowledge that I will not hold Ardon liable for sending medications in this manner and further acknowledge that if such medications are stolen or damaged, I will bear sole financial responsibility (subject to any applicable benefits under my health benefit plan) for the cost of replacing such specialty medications.

Patient's signature and/or signature of legal representative X	Date (mm/dd/yyyy)
Patient's address	

Ready to submit?
Mail this form to Ardon Health, PO Box 20338, Portland, OR 97294. Or, fax it to 855-425-4096.

Questions? Call 855-425-4085 or visit ardonhealth.com.