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CONSENT TO OBTAIN ELECTRONIC MEDICATION HISTORY

I understand that my medication history may be obtained utilizing an electronic information exchange and that this protected health information may provide valuable information for my healthcare provider.

I hereby authorize the physician to access my medication history without limitation or exclusion as is required and/or reasonably advisable to disclose, process, retrieve, transmit, and view for the purpose of the transmission of an electronic prescription issued by a provider authorized by law to prescribe, as necessary for my care and treatment.

Pharmacy Name

Pharmacy Location

Preferred Lab

Signature

Printed Name

Date