CONSENT TO OBTAIN ELECTRONIC MEDICATION HISTORY

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

I hereby authorize Advance Eye Care & Glaucoma Center to access my medication history without limitations or exclusions 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.

Patient Name: _____

Pharmacy Name: _____

Pharmacy Address: Street: _____City:_____

Pharmacy Phone Number: _____

Patient Signature: _____

Date: _____