Clermont Medical Center
BOARD CERTIFIED FAMILY PHYSICIANS

Consent to Access External Prescription History

Name: _____ Birth date: _____ Date: _____

Please sign only after you read and understand the following:

I authorize CLERMONT MEDICAL CENTER and their providers to view my external prescription history via RxHub prescription service.

I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and office staff, and it may include past prescriptions from several years ago. I understand this will allow my providers to better coordinate my care and medication history to maximize the effectiveness and safety of my treatment plan.

My signature certifies that I have read, understand and authorize the access of external prescription history.

_____ _____

Signature of the patient Authorized Representative

_____ _____

Printed Name Printed Name

If authorized representative, relationship to patient: _____