South Central Human Relations Center

CONSENT TO OBTAIN MEDICATION HISTORY

Patient ID: _____

As a user of an electronic medical record, South Central Human Relations Center would like to include your medication history in your record. A medication history is a list of prescription medicines that we or other doctors have prescribed for you. This list is collected from several sources, including your pharmacy and your health insurance and electronic medical records.

An accurate medication history is very important to help us treat you and to avoid potentially dangerous drug interactions and for obtaining prior authorizations that are often required by your insurance companies. By signing this consent form, you give us permission to collect, and give your pharmacy and your health insurance permission to give us, information about all prescriptions that have been filled at any pharmacy or covered by any health insurance. This includes prescription medication to treat AIDS/HIV and mental health conditions. This information will become part of your electronic medical record.

This medication history is a useful guide, but it may not be complete. Some pharmacies do not make drug history available to us, and the drug history might not include drugs that you purchased without using your health insurance. Your medication history might not include over-the-counter medicines, supplements, or herbal remedies. It is still very important for us to take the time to discuss everything you are taking, and for you to tell us about any errors in your medication history.

_____ I give permission for South Central Human Relations Center to obtain my medication history from my pharmacy, my health insurance, my medical records, and my other healthcare providers.

_____ I DO NOT give permission for South Central Human Relations Center to obtain my medication history from my pharmacy, my health insurance, my medical records nor my other healthcare providers.

_____ _____

Print Patient Name Patient's Date of Birth

_____ _____

Signature of Patient or Guardian Relationship to Patient

_____

Date