AUTHORIZATION FOR RELEASE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Authorization to Release Medical Records: I authorize the custodian of records or other person/entity (specifically describe) to disclose/release the following information* (check all applicable):
All Records____ Billing Records____ Other _____

Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse or STDs, you are hereby authorizing disclosure of this information.

To (Name): _____ Relationship: _____

Signature of Patient (or Guardian):_____

Date: _____ / _____ / _____

__ I **do not** authorize Southern Immediate Care to release information about my medical treatment (PHI) without my written consent

CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY/E-PRESCRIBING CONSENT FORM

ePrescribing is defined as a physician's ability to electronically send an understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety.

By Southern Immediate Care and its Affiliated Providers, you allow us to view your external prescription history via the RxHub service and PDMP. This will provide the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my provider and staff here, and it may include prescriptions back in time for several years.

By signing this consent form you are agreeing that Southern Immediate Care and its Affiliated Providers can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

My signature certifies that I read and understood the scope of my consent and that I authorize the access.

_____ _____

Signature of Patient or Legal Guardian Date

_____ PRINT PATINET'S NAME (LEGAL GUARDIAN,IF APPLICABLE)

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