Authorization to Obtain Medication History

Patient Name: ______________________________

Date of Birth: ______________________________

SSN: ______________________________

Address: ______________________________

____

By signing below, I hereby authorize River Hills Community Health Center to obtain medication history related to the patient above, from community pharmacies and/or pharmacy benefit managers for the purpose of continued treatment.

____
Date of Authorization

____
Patient/Legal Representative or Parent/Legal Guardian Print Name

____
Patient/Legal Representative or Parent/Legal Guardian Signature

I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. River Hills Community Health Center may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of this authorization.