Hunt Regional Medical Partners

PATIENT MEDICATION CONSENT FORM

I do herby give Hunt Regional Medical Partners consent to access my medication history electronically.

Pharmacy Name(s): _____

_____

Pharmacy Location and Phone Number (if known):

_____

_____

I understand that electronically accessing my medication history allows my doctor to receive critically important information on my current and past prescriptions and to become better informed about potential medication issues.

Patient Name (please print): _____

Date of Birth: _____

Signature: _____

Relationship to Patient: _____

Date: _____