# The DeWitt Clinic, P.A.

## Prescription History Consent

**Patient:**_____ **DOB:** _____
**PLEASE PRINT NAME**

I voluntarily consent to provide The DeWitt Clinic, PA access to and use of my prescription medication history from other healthcare providers or third party pharmacy, and the Texas Pharmacy Board for treatment purposes. I understand that my prescription history (which includes but is not limited to prescriptions, labs, and other health care drug historical information) from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff, and it may include prescriptions dating back for several years.

I acknowledge that The DeWitt Clinic, PA may use health information exchange systems to electronically transmit, receive and/or access my prescription history.

I understand that this **Prescription History Consent** will be valid and remain in effect, unless revoked by me in writing with such written notice provided to The DeWitt Clinic, P.A.

**By signing below, I acknowledge that I have read this consent or it has been read to me.**

**Signature of Patient/Legally Authorized Representative:** **DATE:**

_____ _____

**Relationship to patient of Legally Authorized Representative:**

_____

For patients requiring translation or verbal reading of this document, the person reading or translating should document and sign below:

_____

Person translating or reading form to patient – Please print