

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.