Children's Care Pediatrics

Rx Consent Form

_____ _____
Patient Name *Patient Date of Birth*

Consent

By signing this consent form you are agreeing that your provider at Children's Care Pediatrics may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

You may decide not to sign this form. Your choice will not affect your ability to get medical care, payment for your medical care, or your medical care benefits. Your choice to give or deny consent may not be the basis for denial of health services. You also have a right to receive a copy of this form after you have signed it.

This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing but if you do, it will not have an effect on any actions taken prior to receiving the revocation.

Understanding all of the above, I hereby provide informed consent to Children's Care Pediatrics to enroll me in this ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____ _____
Preferred Pharmacy Name *Preferred Pharmacy Address*

(_____)_____
Preferred Pharmacy Phone

_____ _____
Signature of Patient or Guardian *Relationship to patient*

_____
Date