Consent for Medication History

By signing this form, I give consent for Carroll Arthritis, P.A. to obtain my medication history from the e-prescribing network system. This information will be used by the providers of Carroll Arthritis for the sole purpose of keeping current the medications listed in my medical record.

Patient Name (printed): _____

DOB: _____

Patient Signature: _____

Date: _____

Please provide your current pharmacy information. If this information changes in the future, then notify the receptionist.

Patient Name: _____

Local Pharmacy: _____Location/phone#_____

Mail Away Pharmacy (if applicable): _____

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