MEDNAX®
HEALTH SOLUTIONS PARTNER

CONSENT FOR E-PRESCRIBING & MEDICATION HISTORY

I understand that as a part of my electronic health record, Pediatric Cardiology Associates will transmit my prescriptions electronically as permitted, to the pharmacy that I delegate as my primary pharmacy provider. Additionally, Pediatric Cardiology Associates will obtain the history of all of my past prescriptions dating back two years from pharmacy benefit managers and I understand that those prescriptions will become a part of my electronic health record.
E-Prescribing greatly reduces medication errors and enhances patient safety.
Features of our ePrescribe program include:

- Formulary and benefit transactions- Provides us with information about which drugs are covered by the drug benefit plan.
- Medication history transactions- Provides us with information about medications you are already taking.
- Fill status notification- Sends us an electronic notice that your prescription has been picked up.

By signing this consent form you are agreeing that we can ePrescribe for you and request your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

☐ I hereby provide informed consent to enroll me in the ePrescribe program.

☐ I decline this option. I do not give permission for access to the above information.

Pharmacy Information

Pharmacy Name: _____

Address: _____

Phone: _____

Fax: _____

_____ DOB: / /
Print Patient Name

_____ _____
Signature of Patient or Legal Representative **Date**