Patient Name: _____ DOB:_____

CONSENT FOR E-PRESCRIBING & MEDICATION HISTORY

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

Features of our e-Prescribe program include:

- Formulary and benefit transaction- 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.
- Fills 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 e-Prescribe for you and request your prescriptions 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 e-Prescribe program.

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

Pharmacy Information

Pharmacy Name: _____

Address: _____

Phone: _____ Fax: _____

_____ _____

Signature of Patient or Legal Representative Date