ePrescribing Notice to Patients

ePrescribing is submitting a prescription to your pharmacy through the internet. The ability to ePrescribe is an important element in improving the quality of patient care by reducing medication errors and enhancing patient safety.

Through ePrescribing your physician may also obtain ***medication history*** (information about the medications you are already taking or have taken within the past year) when applicable for the purpose of coordinating your treatment. Having an accurate list of your medications is critical to providing good medical care.

☐ **YES,** I allow my physician to obtain ***medication history*** (check box)

☐ **NO,** I do not allow my physician to obtain ***medication history*** (check box)

Note: while you may not allow us to obtain your medication history, we may still submit an ePrescription. Alternatively, we may also provide a paper prescription.

If I choose not to allow my physician to access my medication history through ePrescribing, I understand that my physician may not be aware of all medications prescribed by others. Therefore, I am solely responsible for informing my physician about medications I have been prescribed by other physicians or prescribers. I acknowledge and accept any and all risks, including the risk of adverse drug events, associated with my physician not having access to my medication history through ePrescribing.

By signing below, I confirm that I have read and understand all of the above, that I have had the chance to ask questions and all of my questions have been answered to my satisfaction, and that I am eligible to sign this form on behalf of myself/the patient.

Patient Name (Print)_____

Signature of Patient/Parent/Guardian/_____
Health Care Agent/Other Surrogate **Date**

Relationship to Patient _____

PLEASE PROVIDE PREFERRED PHARMACY INFORMATION:

Pharmacy Name _____

Pharmacy Address_____

Pharmacy Telephone Number_____