



# ***Bluff City Obstetrics and Gynecology***

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## **Rx History Consent**

By signing this consent form, you are agreeing that your provider at Bluff City Obstetrics and Gynecology 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 influence any actions taken prior to receiving the revocation.

Understanding all the above, I hereby provide informed consent to Bluff City Obstetrics and Gynecology, to enroll me in this ePrescribe Program. I have had the chance to ask questions and all my questions have been answered to my satisfaction.

Today's Date \_\_\_\_\_

Patient Name (Print) \_\_\_\_\_ Date of Birth \_\_\_\_\_

Signature of Patient or Guardian \_\_\_\_\_