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Hickory, NC 28602

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CONSENT TO ACCESS PRESCRIPTION HISTORY

PATIENT’S NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CHART #\_\_\_\_\_\_\_\_\_\_

DATE OF BIRTH\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Unifour Family Practice, PLLC uses an electronic medical record that allows them to electronically send prescriptions directly to the pharmacies. Our system also allows our physicians to access a list of prescriptions filled by their patients within the past 2 years. Reviewing this list helps to assure patient safety and avoid duplication of medications and/or drug interactions. Please select one of the following and sign below.

* \_\_\_\_\_\_\_\_\_ I grant Unifour Family Practice permission to access my prescription history fromother pharmacies and physician.
* \_\_\_\_\_\_\_\_I do not wish to grant Unifour Family Practice permission to access my prescription history fromother pharmacies and physicians.

Signature of Patient/or legal guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Witness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_