Consent for Release of Electronic Prescribing

I authorize the Asthma and Allergy Institute to submit my prescriptions through Surescripts electronically.

MY SIGNATURE CERTIFIES THAT I HAVE READ AND UNDERSTAND THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

______________________	__________	________________________________
Printed Patient Name	Date	Patient's Signature

My preferred Pharmacy is ____

Address: ____ Phone: ______________

Consent for Release of Prescription History and Automatic Prescription Benefits

I authorize the Asthma and Allergy Institute to access my prescription history and automatically download my prescription benefits from unaffiliated medical providers, insurance companies, and pharmacy benefit managers.

MY SIGNATURE CERTIFIES THAT I HAVE READ AND UNDERSTAND THE SCOPE OF MY CONSENT AND THAT I DO AUTHORIZE THE ACCESS.

______________________	__________	________________________________
Printed Patient Name	Date	Patient's Signature

Consent for Release of Electronic Radiology and Laboratory Medical Records

I authorize the Asthma and Allergy Institute to access and download my medical records electronically regarding laboratory and radiology tests/results from unaffiliated medical providers and medical facilities.

MY SIGNATURE CERTIFIES THAT I HAVE READ AND UNDERSTAND THE SCOPE OF MY CONSENT AND THAT I DO AUTHORIZE THE ACCESS.

______________________	__________	________________________________
Printed Patient Name	Date	Patient's Signature