Orthopaedic Associates of Osceola

Consent For Electronic Prescribing

Patient Name : _____

Account # : _____

Orthopaedic Associates of Osceola is enrolled in an electronic prescribing program. This program is meant to help our providers with understanding what medications our patients are currently using and to give them the best possible treatment.

By signing this form, you are consenting to Orthopaedic Associates of Osceola retrieving electronic prescribing information from other prescribers through the Sure Scripts database.

This consent will only be valid for one year and re-consent will be required at that time.

_____ I agree that Orthopaedic Associates of Osceola may request and use my prescribing medication history from other healthcare providers.

_____ _____

Patient signature Printed name

Date of Consent: _____

Pharmacy Name _____

Address: _____

Pharmacy Phone Number: _____