Consent to Obtain External Prescription History

I, ____ , whose signature appears below, authorize Midtown Neurology, P.C. and its Affiliated Providers to view my external prescription history via our electronic health record system, eClinicalWorks.

I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and authorized staff here, and it may include prescriptions back in time for several years.

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

Signature: ______________________ Date: ____________________