Clocktower Medical Group
Brian McNiece, MD, Family Medicine

Patient Name: _____

Date of Birth: _____

CONSENT TO OBTAIN PRESCRIPTION HISTORY

This consent form authorizes Clocktower Medical Group, LLC to obtain and review my prescriptions history. Detailed prescription history provides your physician with information about medications being prescribed by other providers involved in your medical care. This information will improve the accuracy of our medication list in your medical chart and decrease any adverse drug reactions or inaccurate medication information such as medication names or dosages.

By signing this consent form, you agree that Clocktower Medical Group, LLC can request and use your prescription medication history from other healthcare providers, pharmacies, and benefit payors (such as your insurance company) for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Clocktower Medical Group, LLC to request, view, and use my external prescription history for treatment purposes. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

PATIENT NAME (Printed): _____

PATIENT DATE OF BIRTH: _____

PATIENT SIGNATURE: _____

DATE OF SIGNING CONSENT FORM: _____

Brian D. McNiece, MD
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