COMPEAN
FAMILY MEDICINE

327 Stewart Road
Monroe, MI 48162

734-384-3660 phone
734-384-3661 fax

CONSENT TO OBTAIN AND SEND MEDICATION INFORMATION ELECTRONICALLY

PATIENT'S
NAME _____ DATE_____

DATE OF BIRTH _____/_____/_____ LAST 4 NUMBERS OF SOCIAL SECURITY NO: _____

I _____, hereby voluntarily consent to give permission to Compean Family Medicine to receive electronically my medication benefits and medication history from my pharmacy by way of a technology partner contracted with Compean Family Medicine.

I further consent to give permission to Compean Family Medicine to electronically send medications ordered to a pharmacy by way of a technology partner contracted with Compean Family Medicine.

I agree that the technology partner may need to share my relevant medical information to third parties (i.e. my insurance company, insurance company designated pharmacy clearinghouse) in order to obtain the requested medication benefits, medication history information and to process electronically the medications ordered.

I understand that this form will be valid and remain in effect as long as I receive medical care at Compean Family Medicine.

My signature below indicates that I have read and agree with the information in this document. If you do not understand or consent to anything stated in this document, it is your responsibility to request and receive clarification before signing.

_____

Date **Signature** **Witness**

If signed by patient's authorized representative, describe the representative's authority:

- ☐ Patient is a minor; I am the patient's parent and natural guardian.
- ☐ Patient is a minor; I am the patient's guardian, appointed by the _____County Juvenile Court.
- ☐ Patient is a ward; I am the patient's guardian, appointed by the _____County Probate Court.
- ☐ I am the patient's attorney in fact, as designated in the patient's Durable Power of Attorney for Health Care.
- ☐ Other (describe) _____

_____

Date **Signature** **Witness**