PEDIATRIC EPILEPSY & NEUROLOGY SPECIALISTS

Consent to Obtain External Prescription History

I, _____, whose signature appears below, authorize Pediatric Epilepsy and Neurology Specialists and its affiliated providers to view my child's external prescription history via the RxHub service. Further information can be obtained at www.LearnAboutePrescriptions.com.

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

My signature certifies that I read and understand the scope of my consent and that I authorize access.

_____ _____
Print Patient Name Patient DOB

_____ _____
Parent/Legal Guardian Signature Date

_____ _____
Witness Signature Date

PHARMACY INFORMATION:

Pharmacy Name: _____

Pharmacy Phone # or Address: _____

_____

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