Authorization to Obtain Medication History

PATIENT NAME: ____
LAST FIRST MI

DATE OF BIRTH: _____-_____-_____ SS#: _____-_____-_____ CHART #: __________________

ADDRESS: __________________________________ CITY: _________________ STATE: _____ ZIP: _______

WORK or HOME PHONE: _________________________ CELL PHONE: ____________________________

By signing below, I hereby authorize Capital Area Orthopedic Associates to obtain Medication History related to the patient above from Pharmacies or other healthcare providers for treatment purposes.

Date of Authorization: ______________________________

____
PRINT PATIENT or GUARDIAN or POWER OF ATTORNEY NAME

____ ___________________________
SIGNATURE OF PATIENT or GUARDIAN or POWER OF ATTORNEY DATE

I understand that this authorization is revocable upon written notice where the original authorization is retained, except to the extent that action has already been taken on this authorization. Capital Area Orthopedic Associates may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of this authorization.