CoxHealth

AUTHORIZATION TO OBTAIN MEDICATION INFORMATION

Name of Patient:_____
(first, middle, and last name)

Date of birth of patient: ____/___/_____

TO: MY HEALTHCARE PROVIDERS, PHARMACIES and INSURANCE PROVIDERS

I hereby authorize *(give my permission for)* any of my CoxHealth providers to access information concerning my past, present, and future prescriptions. The information on my prescriptions will come from my pharmacies, my insurance providers, and an electronic health information exchange program, such as SureScripts.

Information may include:

- Eligibility, benefits and formulary information. This helps the provider to select medications that are covered by my insurance company/drug benefit plan. It also informs the provider of lower cost alternatives such as generic drugs.
- Current and past prescriptions, including those prescribed by other providers. This decreases the risk of medication issues such as harmful drug-to-drug interactions or an allergic reaction to a drug.

I further understand:

- I do not have to sign this authorization.
- My refusal to sign will not affect my ability to obtain treatment or my insurance eligibility.
- I can revoke this authorization at any time by submitting a written notice to my healthcare provider(s).
- This authorization will remain in force and effect for one (1) year from the date of my signature or until revoked by me in writing**, whichever occurs first**.
- A photocopy of this authorization will be as valid as an original.

_____ _____

[Signature of patient or legal guardian] Date