PATIENT NAME: _____DATE:_____

Pharmacy Name:_____

Address of Pharmacy:_____

Please list all medications you are currently taking along with the dosage. Make sure to include over the counter meds/supplements (place a check in the box if we prescribe the medication.

Please list a pharmacy even if you are currently not taking any medications.

With your consent we can access your current medications even if prescribed by another physician. By allowing us to do this it will ensure that all medications and dosages are correct in your chart. Please sign below if you give us permission.

Thank you,

I give my consent to access all prescribed medications.

_____ _____

Patient Signature Date