CONSENT TO MEDICATIONS VIA SURESCRIPTS

Date: ______________________________________

Patient Name: ________________________________

Date of Birth: ________________________________

This authorization is prepared to the requirement of the Health Insurance Portability and Accountability Act of 1966 (P.L. 104-91), 42 U.S.C. Section 1320d, et. Seq and regulations promulgated thereunder, as amended from time to time (collectively referred to as "HIPPA").

This authorization affects your rights in the privacy of your Personal Health Care Information (PHI). Please read carefully before signing.

For your convenience and to expedite the process with your selected pharmacy, our office has the option to send your medications via electronic means (Surescripts). This consent authorizes and covers any and all previous (refills) and future medication history, data that may include the pharmacy, notes and prescribing physicians as well as other fields based upon availability.

Patient Signature: __________________________ Date: __________________________

Patient Name: ____

If there are any changes to the above information I understand that I am responsible to contact this office to make the necessary changes in my patient file.

Advanced Internal Medicine
3416 North Buffalo Drive
Las Vegas, Nevada 8929

Ph. 702-982-8700
Fax. 702-982-8282